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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06094 06091

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Dorchester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rhodesdale 09-2
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Nettie Middle: Murphy Last: Adshead
4. DATE OF DEATH: Month: April Day: 25 Year: 1966
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 8/9/1885
9. AGE (In years last birthday): 80 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Patrick Murphy
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown):
(If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address: Mrs Walter Adshead, Sharptown

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.
4200
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Chronic (and Acute) Cholecystitis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 3/22, 1966, to 4/25, 1966, that (I) (we) last saw the deceased alive on 4/25 1966, and that death occurred at 5:30 P.M., from the causes and on the date stated above.

22a. SIGNATURE: David J. Gilmore — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 4/25/66
22c. PHYSICIAN'S NAME (Type): David J. Gilmore
22d. ADDRESS: Salisbury, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 4/27/66
23c. NAME OF CEMETERY OR CREMATORY: East New Market
23d. LOCATION (City, town or county) (State): East New Market Md

24. FUNERAL DIRECTOR: Ruth S. Willoughby
ADDRESS: East New Market
25a. REC'D BY REGISTRAR DATE: MAY 2 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
15M 4-64
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06095 06092

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: all Life
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 514 Collins St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Marrow — Middle: G. — Last: ALLEN

4. DATE OF DEATH: Month: 4 — Day: 2 — Year: 1966

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4-13-1900

9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Snow Hill, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Amanda Allen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Viola Allen - 514 Collins St. Salis.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Astrocytoma Rt Cerebral Hemisphere grade IV — INTERVAL BETWEEN ONSET AND DEATH: 6 months
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1930

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from March, 1966 to 3 Apr, 1966, that (I) (we) last saw the deceased alive on 3 Apr 1966, and that death occurred at 9 P.M., from the causes and on the date stated above.

22a. SIGNATURE: E Parnell M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4, Apr 6

22c. PHYSICIAN'S NAME (Type): E.A. Parnell, Md.

22d. ADDRESS: Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 4-7-66

23c. NAME OF CEMETERY OR CREMATORY: GREEN ACRES MEM. PK.

23d. LOCATION (City, town or county) (State): Salisbury, Md.

24. FUNERAL DIRECTOR — ADDRESS: Loretta B. Jolley - Jersey Rd. Salisbury

25a. REC'D BY REGISTRAR DATE: APR 11 1966

25b. REGISTRAR'S SIGNATURE: J Charles Judge

VR A15 (4)
20M 1/65

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(M)

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06096

CERTIFICATE OF DEATH

06093

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Wicomico — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Caroline
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Federalsburg
   d. STREET ADDRESS: River Road
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Rosa; Middle: ; Last: Andrews

4. DATE OF DEATH: Month: April; Day: 22; Year: 1966

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Nov. 4, 1868

9. AGE (In years last birthday): 97 yrs.

IF UNDER 1 YEAR — Months: ; Days: — IF UNDER 24 HRS. — Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: housewife

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Silas Christopher

14. MOTHER'S MAIDEN NAME: Ellen Dukes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no
    (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT — Address: Mrs. Bertha Magers, Hurlock, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH:
4200
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Uremia; Pneumonia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4/17, 19 66, to 4/22, 19 66, that (I) (we) last saw the deceased alive on 4/22 19 66, and that death occurred at 1 P. M, from the causes and on the date stated above.

22a. SIGNATURE: Maud J. Gilmore M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED:

22c. PHYSICIAN'S NAME (Type):

22d. ADDRESS: Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: April 25, 1966

23c. NAME OF CEMETERY OR CREMATORY: Hillcrest

23d. LOCATION (City, town or county) (State): Federalsburg, Md.

24. FUNERAL DIRECTOR — ADDRESS: H. Hamp Williams - Federalsburg, Md.

25a. RECEIVED BY REGISTRAR — DATE: APR 26 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06097 06094

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Pen.Gen.Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: Carey Avenue 22-1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
HARRY	BARNES	AUSTIN	APRIL	25	1966

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White		May 21/1918	47 yrs.	11	4		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Inspector-Pump Co.	(Employee)	Somerset Co., Maryland	U S A

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Elias Thomas Austin	Viola M.White

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
YES W.W.#II		Mr.Willie W.Austin(Brother)408 East Church Street Salisbury,Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarct — INTERVAL BETWEEN ONSET AND DEATH: 5 minutes
4201
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) N/A
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4- 19 55 to 4-25 19 66 (that (I) (we) last saw the deceased alive on 4-25 19 66, and that death occurred at Apr-5:00P M, from the causes and on the date stated above.

22a. SIGNATURE W.W.Ellis Jr.
M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED Apr. 25/1966
22c. PHYSICIAN'S NAME (Type) Dr. Wilbur R.Ellis Jr.
22d. ADDRESS Medical Center Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
Burial	Apr.29/1966	Parsons Cemetery	Salisbury,Maryland

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
HOLLOWAY & COMPANY	SALISBURY,MARYLAND	MAY 2 1966	Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06098 06095

1. PLACE OF DEATH
a. COUNTY Wicomico PENINSULA GENERAL HOSPITAL MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) PENINSULA GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE Texas Maryland b. COUNTY El Paso Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fruitland El Paso 20-3
d. STREET ADDRESS 7753 Vera Cruz Fruitland e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First: Cecil Middle: William Last: Barrack
4. DATE OF DEATH Month: APRIL Day: 7 Year: 1966
5. SEX: MALE
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug. 4/1924
9. AGE (In years last birthday): 41 yrs. IF UNDER 1 YEAR Months: 8 Days: 3 IF UNDER 24 HRS. Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Army Enlistedman
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Virginia (Weirwood)
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: Harry H. Barrack
14. MOTHER'S MAIDEN NAME: Harriett Anne - Unk
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): YES-W.W.#II & Korea
16. SOCIAL SECURITY NO.: 231-14-0294
17. INFORMANT Address: Mrs. Mary L. Barrack (Wife) 7753 VeraCruz El Paso, Texas

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 12 HRS.
4201
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Coronary atherosclerosis — YEARS
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES XX NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4-6, 1966, to 4-7, 1966 that (I) (we) last saw the deceased alive on 4-6 1966, and that death occurred at 1:36 AM, from the causes and on the date stated above.

22a. SIGNATURE Hubert R. White, Jr. M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED Apr. 8 /1966
22c. PHYSICIAN'S NAME (Type) Dr. Hubert R. White, Jr
22d. ADDRESS Fruitland, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF Apr. 13/1966
23c. NAME OF CEMETERY OR CREMATORY Fort Bliss National Cem.
23d. LOCATION (City, town or county) (State) El Paso, Texas

24. FUNERAL DIRECTOR ADDRESS: HOLLOWAY & COMPANY SALISBURY, MARYLAND
25a. REC'D BY REGISTRAR DATE: APR 14 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 4-64

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06099 06096

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Wicomico
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
   c. LENGTH OF STAY IN 1b
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: MARYLAND
   b. COUNTY: WORCESTER
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BERLIN 23-2
   d. STREET ADDRESS: 21 W WILLIAM ST.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First LILLIAN (LENA) K. Middle Last BETHELL
4. DATE OF DEATH: Month APRIL Day 24, Year 1966
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: OCT. 5, 1880
9. AGE (In years last birthday): 85 yrs. IF UNDER 1 YEAR Months Days; IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SHIRT FACTORY
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (County & State, or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: HENRY NIBBLETT
14. MOTHER'S MAIDEN NAME: ELLEN DAVIS
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 142-14-6326
17. INFORMANT: JOHN RAYNE Address: DOVER, DEL.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
   PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.
   4200
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
   DUE TO (b):
   DUE TO (c):
   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4/15, 1966, to 4/24, 1966, that (I) (we) last saw the deceased alive on 4/24 1966, and that death occurred at 9:25 M, from the causes and on the date stated above.

22a. SIGNATURE: David J. Gilmore — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 4-26-66
23c. NAME OF CEMETERY OR CREMATORY: Buckingham
23d. LOCATION (City, town or county) (State): Berlin, Md.

24. FUNERAL DIRECTOR: William Esham Jr. ADDRESS: Georgetown, Dela.
25a. REC'D BY REGISTRAR DATE: APR 28 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

Trades

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06100 06097

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury (Rural)
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): R.D.# 5 Zion Road

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury (Rural)
d. STREET ADDRESS: R.D.#5 Zion Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
HARRY	GARBER	BIEHN	APRIL	27	1966

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White	MARRIED ☒	April 15/1911	55 yrs.	0	12		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Salesman - Office Equipment		Philadelphia, Pa.	U S A

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Harry T. Biehn	Martha Garber

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
YES W.W.#II	111-07-0703	Mrs. Esther I. Biehn (Wife) R.D.#5 Zion Rd Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: Sudden
4201
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b): DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): By pertinacity — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
	N/A

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from April, 19 66 to April 27, 19 66, that (I) (we) last saw the deceased alive on ____ 19____, and that death occurred at Apr. 6:30 A.M., from the causes and on the date stated above.

22a. SIGNATURE	M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22b. DATE SIGNED
William D Gray		Apr. 28 /1966

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
Dr. William D. Gray	Camden Ave. Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
Burial	May 2/1966	Arlington National	Arlington, Virginia

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
HOLLOWAY & COMPANY	SALISBURY, MARYLAND	MAY 2 1966	J Charles Judge

VR A15 (4)
20M 1/65

xxxxxx

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Exominer's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used os o burial-transit permit. File pages 1 and 2 with the Stote Department of Health or its designated ogent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 9 Film G376 5/3/66 mh

06101

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06098

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside carparate limits, write RURAL and give neorest town): Fruitland
d. STREET ADDRESS: Box 375
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ELWOOD — Middle — Lost BIVANS
4. DATE OF DEATH: Month 4-21-66 — Doy — Year 19

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ / NEVER MARRIED ☐ / WIDOWED ☐ / DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In yeors last birthday)	IF UNDER 1 YEAR: Months / Doys	IF UNDER 24 HRS.: Hours / Min.
M	C		2-28-19	47 38 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Labor	none	Fruitland md	USA

13. FATHER'S NAME: Asher Barkley
14. MOTHER'S MAIDEN NAME: Marva Byrons.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT — Address
WW II			Naomi Byrons

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Acute pancreatitis
DUE TO
(b): Chronic alcoholism
DUE TO
(c):
3221
Conditions, if any, which gave rise to immediate couse (o), stating the underlying couse last.
INTERVAL BETWEEN ONSET AND DEATH: Days / Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ~~OR~~ CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Day, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** thot I took charge of the remoins described obave, held on Autopsy ☒, Inspection ☒, Inquiry ☒, ond in my opinion deoth resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer M.D.
EXAMINER'S NAME (Type): Earl L. Royer, M.D.
Address (Street, city, town, or county): 409 Camden Ave., Salisbury, Md.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22. DATE SIGNED: April 23, 1966

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	4-24-66	Byrons Cem	Fruitland Md.

24. FUNERAL DIRECTOR: Booker McWest. — ADDRESS

25a. REC'D BY REGISTRAR DATE: APR 27 1966
25b. REGISTRAR'S SIGNATURE: J Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1 M

06102 06099

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 4yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fruitland 22-1
d. STREET ADDRESS: Morris St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: David Middle: A. Last: Black

4. DATE OF DEATH: Month: April Day: 9 Year: 1966

5. SEX: Male

6. COLOR OR RACE: C

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2-10-88

9. AGE (If years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (County & State, or foreign country): Wicomico Co

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Andrew Block

14. MOTHER'S MAIDEN NAME: Amelia Pockum

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: 217-36-6532

17. INFORMANT: Dina Block Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion
4201
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Asteriosclerotic heart disease
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: MIN. / YEARS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Acute asthmatic bronchitis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from 4-5, 1966, to 4-9, 1966; that (I) (we) last saw the deceased alive on 4-8 1966, and that death occurred at 12:45 M, from the causes and on the date stated above.

22a. SIGNATURE: Robert R. White Jr. M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED:

22c. PHYSICIAN'S NAME (Type):

22d. ADDRESS:

23a. BURIAL, ~~CREMATION, REMOVAL~~ (Specify): 4/13/66

23b. DATE THEREOF:

23c. NAME OF CEMETERY OR CREMATORY: Mt. Calvary

23d. LOCATION (City, town or county) (State): Fruitland, Md

24. FUNERAL DIRECTOR: Booker M. Watts ADDRESS: Salisbury, Md.

25a. REC'D BY REGISTRAR DATE: APR 12 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06103 06100

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 124 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Delmar
d. STREET ADDRESS: 3rd Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Arlanta; Middle: ; Last: Blaylock

4. DATE OF DEATH: Month: 4; Day: 30; Year: 19 66

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 11-28-1887

9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Maintenance

10b. KIND OF BUSINESS OR INDUSTRY: Railroad

11. BIRTHPLACE (County & State, or foreign country): Snow Hill, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Lank

14. MOTHER'S MAIDEN NAME: Priscilla Cherrix

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): --------

16. SOCIAL SECURITY NO.: 716-01-6693

17. INFORMANT: Catharine Hines, Prince Frederick, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), end (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Recurrent cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3 days, yrs.
332 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year; Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 12/27, 19 65, to 4/30, 1966, that (I) (we) last saw the deceased alive on 4/30 1966, and that death occurred at 4:27 P.M. from the causes and on the date stated above.

22a. SIGNATURE: W Maldve — M.O. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 5/2/66

22c. PHYSICIAN'S NAME (Type): L. V. Maldve, M. D.

22d. ADDRESS: Deer's Head State Hospital; Salisbury, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5-3-66

23c. NAME OF CEMETERY OR CREMATORY: St Stephens

23d. LOCATION (City, town or county) (State): Delmar, Del

24. FUNERAL DIRECTOR ADDRESS: Charles W. Marvel, Delmar, Del.

25a. REC'D BY REGISTRAR DATE: MAY 4 1966

25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06104 06101

1. PLACE OF DEATH
a. COUNTY: Wicomico MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Medical Center

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: New York b. COUNTY: Kings
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brooklyn
d. STREET ADDRESS: 531 E.22nd Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ROSE Middle (NMI) Last BORGER
4. DATE OF DEATH: Month APRIL Day 5th Year 1966
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Nov.5/1898
9. AGE (In years last birthday): 67 yrs. IF UNDER 1 YEAR: Months 5 Days 0 IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (County & State, or foreign country): Austria
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: Morris Bader
14. MOTHER'S MAIDEN NAME: Fannie (Unk)
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 110-28-1122
17. INFORMANT: Mrs. Sidney (Anne B.) Advocat (Daughter) Address: 1405 Allenwood Dr. Salisbury, Md. 21801

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): MYOCARDIAL INFARCTION — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs.
4201
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
DUE TO (b): ARTERIOSCLEROTIC HEART DISEASE
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): N/A
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from 5 Apr, 19 66, to 5 Apr, 19 66, that (I) ~~(we)~~ last saw the deceased alive on 5 Apr 19 66, and that death occurred at 4 PM, from the causes and on the date stated above.

22a. SIGNATURE: A. Gray Reeves M.D. M.O. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Apr. 5 /1966
22c. PHYSICIAN'S NAME (Type): Dr. H. Gray Reeves
22d. ADDRESS: Medical Center Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Apr. 7/1966
23c. NAME OF CEMETERY OR CREMATORY: Beth Israel Cemetery
23d. LOCATION (City, town or county) (State): Woodbridge, New Jersey

24. FUNERAL DIRECTOR: HOLLOWAY & COMPANY ADDRESS: SALISBURY, MARYLAND
25a. REC'D BY REGISTRAR DATE: APR 11 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06105

CERTIFICATE OF DEATH

06102

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Wicomico — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
   c. LENGTH OF STAY IN 1b: 2 1/2 wks
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: MARYLAND — b. COUNTY: Wico.
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
   d. STREET ADDRESS: 213 PINEWAY
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First BLANCHE — Middle MAE — Last BOSMAN

4. DATE OF DEATH: Month APRIL — Day 29 — Year 1966

5. SEX: Female — 6. COLOR OR RACE: White — 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: JAN. 25, 1889

9. AGE (In years last birthday): 77 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (County & State, or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: MILLARD F. EVANS

14. MOTHER'S MAIDEN NAME: HENRIETTA R. WHITE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No

(If yes give war or dates of service): —

16. SOCIAL SECURITY NO.: UNKNOWN

17. INFORMANT: MILLARD W. BOSMAN — Address: 284 WALNUT ST. POCOMOKE, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Embolism, Thrombosis & Bleeding Ulcers (Corrected) — INTERVAL BETWEEN ONSET AND DEATH

332X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Cerebral Thrombosis

DUE TO (c): Marked Arteriosclerosis Cerebral & Generalized

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. 7:35 am p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) Salisbury (County) Wicomico (State) Md

21. I certify that (I) (this hospital) attended the deceased from 4/10/66, 19__ to 4/29/66 19__, that (I) (we) last saw the deceased alive on 4/29/66 19__, and that death occurred at 7:35 AM, from the causes and on the date stated above.

22a. SIGNATURE: Carrie Hearn — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4-29-1966

22c. PHYSICIAN'S NAME (Type): CARRIE HEARN

22d. ADDRESS: 226 N. Division St Salisbury Md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 5/1/1966

23c. NAME OF CEMETERY OR CREMATORY: ALLEN CEM.

23d. LOCATION (City, town or county) (State): ALLEN, MD

24. FUNERAL DIRECTOR: HILL TYN HOME — ADDRESS: SALISBURY, MD.

25a. REC'D BY REGISTRAR: DATE MAY 3 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
15M 4-64

BP

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06106

CERTIFICATE OF DEATH

06103

1. PLACE OF DEATH
a. COUNTY: WICOMICO — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): PENINSULA GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WORCESTER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SNOW HILL
d. STREET ADDRESS: WASHINGTON
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First WILLIAM Middle JAMES Last BOUNDS.

4. DATE OF DEATH: Month APRIL Day 20, Year 1966

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: July 26 1882

9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Store Keeper

10b. KIND OF BUSINESS OR INDUSTRY: Grocery

11. BIRTHPLACE (County & State, or foreign country): Somerset County

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George T. Bounds

14. MOTHER'S MAIDEN NAME: Mary Ann Curtis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: Preston W. Bounds, Snow Hill, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 wks

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerosis — 4 years
DUE TO (c): Diabetes Mellitus — 5 years

260 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan., 1966, to Apr., 1966 that (I) (we) last saw the deceased alive on Apr 20 1966, and that death occurred at 6 P.M., from the causes and on the date stated above.

22a. SIGNATURE: David Rafat. M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): DAVID RAFAT

22d. ADDRESS: SNOW HILL Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: April 23, 1966

23c. NAME OF CEMETERY OR CREMATORY: Christian Cemetery
ADDRESS

23d. LOCATION (City, town or county) (State): Snow Hill Md

24. FUNERAL DIRECTOR: Thomas F. Mumma, Snow Hill, Md

25a. FILED BY REGISTRAR DATE: APR 25 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

M 06107 — 06104

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 14 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Delaware
b. COUNTY: Sussex
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Seaford — RURAL 46-3
d. STREET ADDRESS: R#1 Box 391
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Maude — Middle: ELIZABETH — Last: Bowden
4. DATE OF DEATH: Month: April — Day: 29 — Year: 1966
5. SEX: Female
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: DEC 23 1892
9. AGE (In years last birthday): 73 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: OWN Home
11. BIRTHPLACE (County & State, or foreign country): DELAWARE
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: THEODORE F. BLADES
14. MOTHER'S MAIDEN NAME: ANNIE BOSWELL
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO
(If yes give war or dates of service): —
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: RONALD F. BOWDEN — SEAFORD, DEL.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Atherosclerotic Cardiovascular Disease — INTERVAL BETWEEN ONSET AND DEATH
4221
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4-16-, 1966, to 4-29-, 1966, that (I) (we) last saw the deceased alive on 4-28-1966, and that death occurred at 1:30 M, from the causes and on the date stated above.

22a. SIGNATURE: James L. Clifford M.D. — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 4/29/66
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS: Medical Center Salisbury MD

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: MAY 1, 1966
23c. NAME OF CEMETERY OR CREMATORY: ODD FELLOWS CEMETERY
23d. LOCATION (City, town or county) (State): SEAFORD, DELAWARE

24. FUNERAL DIRECTOR: Paynter M. Watson — ADDRESS: SEAFORD DELAWARE
25a. REC'D BY REGISTRAR DATE: MAY 3 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06108 06105

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Snow Hill
d. STREET ADDRESS: Franklin St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

23-2

3. NAME OF DECEASED (Type or print): First: D. — Middle: Hargis — Last: Bradford
4. DATE OF DEATH: Month: April — Day: 19 — Year: 1966
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feb. 19 1904
9. AGE (In years last birthday): 62 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Owner & Operator
10b. KIND OF BUSINESS OR INDUSTRY: Auto Agency
11. BIRTHPLACE (County & State, or foreign country): Snow Hill Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Daniel H. Bradford
14. MOTHER'S MAIDEN NAME: Alice M. Sturgis
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 219320312
17. INFORMANT — Address: Elsie P. Bradford, Snow Hill Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 8 days.
157X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Adenocarcinoma —
DUE TO (c): probably Pancreatic — 18 mo.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Feb, 19 66, to Apr., 19 66, that (I) (we) last saw the deceased alive on Ap. 18 19 66, and that death occurred at 9 A.M., from the causes and on the date stated above.

22a. SIGNATURE: David Rafar W., M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 4-20-66
22c. PHYSICIAN'S NAME (Type): DAVID RAFAT
22d. ADDRESS: Snow Hill Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 4-21-66
23c. NAME OF CEMETERY ~~OR CREMATORY~~: Whatcoat Methodist
23d. LOCATION (City, town or county) (State): Snow Hill Md.
24. FUNERAL DIRECTOR — ADDRESS: Forman F. Glenn, Snow Hill, Md.
25a. REC'D BY REGISTRAR — DATE: APR 21 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
15M 4-64

1 (M)

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06109

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06106

1. PLACE OF OEATH
   a. COUNTY: Wicomico — MARYLAND
   b. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest town): Salisbury
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Beninsula General Hospital

2. USUAL RESIOENCE (Where deceosed lived, if institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Wicomico
   c. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest town): Mardela Springs
   d. STREET ADDRESS: RFD 1
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First PERCY — Middle ROGERS — Lost BROWN

4. OATE OF OEATH: Month 4-23-66 — Ooy — Year 19

5. SEX: M

6. COLOR OR RACE: AA

7. MARRIED ☑ NEVER MARRIEO ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10-25-15

9. AGE (In yeors lost birthday): 50 yrs.

IF UNDER 1 YEAR: Months — Doys
IF UNDER 24 HRS.: Hours — Min.

10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Factory

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Levi Hill

14. MOTHER'S MAIDEN NAME: Elizabeth Brown

15. WAS OECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dotes of service): yes WW No 2

16. SOCIAL SECURITY NO.:

17. INFORMANT: Address: Mrs. Elizabeth Brown Camden Ave

MEDICAL CERTIFICATION

18. CAUSE OF OEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Crushed chest — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO
(b):
DUE TO
(c):
Conditions, if ony, which gave rise to immediate couse (o), stoting the underlying couse lost.

8169

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL OISEASE CONDITION GIVEN IN PART 1(o)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20o. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
Driver of vehicle that collided with parked vehicle.

20c. TIME OF INJURY Month, Doy, Year Hour o.m.: 1:30 PM 4-23-66

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Ghost Light Road

20f. (City or town) (County) (State): Hebron, Wicomico, Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer M.D.

EXAMINER'S NAME (Type): Earl L. Royer, M.D.

Address (Street, city, town, or county): 409 Camden Ave., Salisbury, Md.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
OEPUTY MEDICAL EXAMINER ☒

22. OATE SIGNEO: April 25, 1966

23o. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4-28-66

23c. NAME OF CEMETERY OR CREMATORY: Sharptown, Cem.

23d. LOCATION (City or Town) (County) (State): Wicomico Md.

24. FUNERAL DIRECTOR: James D. Marshall — ADDRESS: Easton, Md.

25o. REC'O BY REGISTRAR — OATE: APR 29 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Jones

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06110 Information from birth Cert. 07663

1 M C

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MD
b. COUNTY: Wor
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Berlin 23-1
d. STREET ADDRESS: Route 3, Box 216
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First — Middle — Last: Bryant
4. DATE OF DEATH: Month: April — Day: 26 — Year: 1966
5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 4-26-66
9. AGE (In years last birthday): yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours: 1 — Min.: 54
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (County & State, or foreign country): Wicomico
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Clarence Bryant
14. MOTHER'S MAIDEN NAME: Tommy Powell
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown)
(If yes give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — Address: Tommy Bryant - Rt #3 Berlin, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Immaturity (2350 gms) — INTERVAL BETWEEN ONSET AND DEATH: 2 days 4 hours
776X
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4/24, 19 66, to 4/26, 19 66; that (I) (we) last saw the deceased alive on 4/26 19 66, and that death occurred at 1:34 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Alfred C Kolls M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☑
22b. DATE SIGNED:
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS: Medical Center - Salisbury, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 4-28-66
23c. NAME OF CEMETERY OR CREMATORY: New Bethel
23d. LOCATION (City, town or county) (State): Berlin Md.

24. FUNERAL DIRECTOR: Loretta B. Jolley
ADDRESS: Jersey Rd. - Sali.
25a. REC'D BY REGISTRAR DATE: MAY 10 1966
25b. REGISTRAR'S SIGNATURE: J Charles Judge

E-220226

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06111 06107

1. PLACE OF DEATH
a. COUNTY: Wicomico
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Pen.Gen.Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 610 Camden Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

22-1

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
JOSEPH	SAMUEL	CAREY	APRIL	22	19 66

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White	MARRIED ☒	Sept.12/1893	72 yrs.	7	10		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Ins.Agency	Owner	Wicomico Co., Maryland	U S A

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Joseph Simpson Carey	Laura Jones

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
YES W.W.#One	218-20-7229	Mrs.Blanche H.Carey(Wife)610 Camden Avenue Salisbury,Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Myocardial Infarction	2 days.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. OUE TO (b)	Arteriosclerotic Coronary Artery Disease	Years.
OUE TO (c)	Diabetes Mellitus	Years

260 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 3/31/66, 19 66, to 4/22/66, 19 66, that (I) (we) last saw the deceased alive on 4/22/66, 19 66, and that death occurred at Apr-12:50A M, from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: Apr.23/1966

22c. PHYSICIAN'S NAME (Type): Dr. O.J.Burton

22d. ADDRESS: Medical Center Salisbury,Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
Burial	Apr.24/1966	Wicomico Memorial Park	Salisbury,Maryland

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
HOLLOWAY & COMPANY	SALISBURY,MARYLAND	DATE APR 26 1966	[signature] Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06112 06108

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: WICOMICO
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): PENINSULA GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WICOMICO
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): MARDELA 22.1
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ELLEN Middle Last CARLSON

4. DATE OF DEATH: Month APRIL Day 15 Year 1966

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 4-18-1877

9. AGE (In years last birthday): 88 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): AT HOME

10b. KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (County & State, or foreign country): IRELAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: PATRICK STAPELETON

14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: HELEN DWYER Address: MARDELA MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Dehydration. — INTERVAL BETWEEN ONSET AND DEATH: 8 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Vomiting, obstipation. — 8 days
DUE TO (c): Arteriosclerotic cerebral disease — 4 yrs.

334X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic Cholecystitis.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4/15/1966, to 4/15/1966, that (I) (we) last saw the deceased alive on 4/15/1966, and that death occurred at 11 P.M. from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 4-20-66

23c. NAME OF CEMETERY OR CREMATORY: PEACE DALE

23d. LOCATION (City, town or county) (State): HIGHLAND FALLS, N.Y.

24. FUNERAL DIRECTOR: Charles H. Mann ADDRESS: Delmar, Del

25a. REC'D BY REGISTRAR DATE: APR 18 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06113 — 06109

1 (M)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Peninsula General

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: Jersey Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Maurice — Middle: T. — Last: Chandler

4. DATE OF DEATH: Month: April — Day: 26 — Year: 1966

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 2, 1966

9. AGE (In years last birthday): yrs. — IF UNDER 1 YEAR: Months: — Days: 25 — IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Copes

14. MOTHER'S MAIDEN NAME: Martha Chandler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Martha Chandler Jersey Rd. Salisbury

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Purulent Meningitis due to Proteus Species — INTERVAL BETWEEN ONSET AND DEATH: 8 days
340.3
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Premsturity - Birth wt 1435 gms

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4/21/66 to 4/26/66, that (I) (we) last saw the deceased alive on 4/25/1966, and that death occurred at 7:40 M, from the causes and on the date stated above.

22a. SIGNATURE: Alfred C Kolls — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4/26/66

22c. PHYSICIAN'S NAME (Type):

22d. ADDRESS: Medical Center Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/29/1966

23c. NAME OF CEMETERY OR CREMATORY: Green Acres

23d. LOCATION (City, town or county) (State): Salisbury Md.

24. FUNERAL DIRECTOR — ADDRESS: Clifton E. Stewart Salis Md

25a. REC'D BY REGISTRAR — DATE: MAY 3 1966

25b. REGISTRAR'S SIGNATURE: J Charles Judge

VR A15 (4)
15M 4-64

6-204/96

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06114 06110

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Somerset
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crisfield
d. STREET ADDRESS: 5 Pear St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: CHARLES — Middle: --- — Last: CLARK

4. DATE OF DEATH: Month: APRIL — Day: 25 — Year: 1966

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 16, 1903

9. AGE (In years last birthday): 62 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Boxmaker

10b. KIND OF BUSINESS OR INDUSTRY: Seafood

11. BIRTHPLACE (County & State, or foreign country): Saxis, Va.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George Clark

14. MOTHER'S MAIDEN NAME: Bertie Collins

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): None

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Mrs. Cecil Tawes, Same as 2. abcd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Thrombosis of Coronary Artery — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
(b): Extensive Arteriosclerosis
(c): Hypertensive Arteriosclerotic Myocardial Heart Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I — AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

2Df. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4/25/66, 19__ to 4/25/66, 19__, that (I) (we) last saw the deceased alive on ____ 19__, and that death occurred at 5:37 P.M., from the causes and on the date stated above.

22a. SIGNATURE: CARRIE H. HEARN, M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Carrie Hearn, M. D. — 22d. ADDRESS: 216 N. Division St. Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: Apr. 28, 1966 — 23c. NAME OF CEMETERY OR CREMATORY: Sunnyridge Cemetery — 23d. LOCATION (City, town or county) (State): Crisfield, Md.

24. FUNERAL DIRECTOR — ADDRESS: Bradshaw & Sons, Crisfield, Md.

25a. REC'D BY REGISTRAR DATE: MAY 2 1966 — 25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
15M 4-64

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06115

CERTIFICATE OF DEATH

06111

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 11 Mons.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Spring Hill Pr. Sana.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 511 N. Pinehurst Ave.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: HORACE — Middle: MILLER — Last: CLARK
4. DATE OF DEATH: Month: 4 — Day: 6 — Year: 1966
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Sept. 17, 1881
9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Roads Engineer, Retired
10b. KIND OF BUSINESS OR INDUSTRY: County Roads
11. BIRTHPLACE (County & State, or foreign country): New Jersey
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Louis F. Clark,
14. MOTHER'S MAIDEN NAME: Clara chapin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no
16. SOCIAL SECURITY NO.: 218-34-9496A
17. INFORMANT — Address: Mrs. Richard W. Cooper, Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO (b): Generalized Arteriosclerosis — 10 yrs.
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
DUE TO (c):
332X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Parkinsons Disease - Degenerative Heart Disease
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Dec 19 66 to 4/6 19 66, that (I) (we) last saw the deceased alive on 4/6 19 66, and that death occurred at 6:4 M. from the causes and on the date stated above.

22a. SIGNATURE: Earl Beardsley M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 4-6-1966
22c. PHYSICIAN'S NAME (Type): Dr. Earl M. Beardsley
22d. ADDRESS: Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 4-8-1966
23c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery
23d. LOCATION (City, town or county) (State): Salisbury, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Hill Funeral Home — Norman T. Baker
ADDRESS: Salisbury, Maryland
25a. REC'D BY REGISTRAR DATE: APR 11 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06116

CERTIFICATE OF DEATH

06112

1. PLACE OF DEATH
   a. COUNTY: Wicomico — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Delmar
   c. LENGTH OF STAY IN 1b: 1Hr.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): 200 East St.,

2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Wicomico
   c. CITY OR TOWN (If outside corporote limits, write RURAL ond give neorest town): Delmar
   d. STREET ADDRESS: 204 Chestnut St.,
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: WILLIAM — Middle: ----- — Last: COFFIN

4. DATE OF DEATH: Month: 4 — Doy: 7 — Year: 19 66

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2-12-1906

9. AGE (In yeors last birthday): 60 yrs.

IF UNDER 1 YEAR: Months / Doys — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Coast Guard

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (County & Stote, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Harry Coffin

14. MOTHER'S MAIDEN NAME: Frances Beauchamp

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give wor or dotes of service)

16. SOCIAL SECURITY NO.: 218-20-3909

17. INFORMANT: Mrs. Laura W. Coffin — Address: Salisbury, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), ond (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary artery occlusion — INTERVAL BETWEEN ONSET AND DEATH: minutes
DUE TO (b): Coronary arteriosclerosis — 15 yrs
DUE TO (c):
Conditions, if ony, which gove rise to immediote couse (a), stoting the underlying couse last.

4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Hypertension essential

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Yeor Hour o.m. p.m. 19

20d. INJURY OCCURRED While ot work ☐ Not While ot work ☐

20e. PLACE OF INJURY (Home, form, foctory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from ____, 19 55, to 4-7, 19 66, that (I) (we) last saw the deceased alive on 4-7 19 66, and that death occurred at 8:50 M, from causes and on the date stated above.

22a. SIGNATURE: A. W. Sohler M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4-8-1966

22c. PHYSICIAN'S NAME (Type): Dr. L.V. Sohler

22d. ADDRESS: Delmar, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4-9-1966

23c. NAME OF CEMETERY OR CREMATORY: St. Stephen Cemetery

23d. LOCATION (City or Town) (County) (State): Delmar, Delaware

24. FUNERAL DIRECTOR: Hill Funeral Home — ADDRESS: Salisbury, Maryland

25a. REC'D BY REGISTRAR DATE: APR 12 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

Norman T. Baker

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06117 06113

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): PENINSULA GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pocomoke City 23-2
d. STREET ADDRESS: 327 Linden Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First NETTIE Middle BALLARD Last COLBOURNE
4. DATE OF DEATH: Month April Day 12 Year 1966

5. SEX: FEMALE
6. COLOR OR RACE: NEGRO
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Sept. 12, 1890
9. AGE (In years last birthday): 75 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10b. KIND OF BUSINESS OR INDUSTRY: House wife
11. BIRTHPLACE (County & State, or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph Ballard
14. MOTHER'S MAIDEN NAME: Sarah Nelson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT Address: John M. Coulbourne, Linden Ave. Pocomoke, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: few hours
332X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4-6, 1966, to 4-12, 1966 that (I) (we) last saw the deceased alive on 4-12 1966, and that death occurred at 8:17 M, from the causes and on the date stated above.

22a. SIGNATURE: Willard R. Todd M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 4-12-66
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 4-16-66
23c. NAME OF CEMETERY OR CREMATORY: Evergreen Cem.
23d. LOCATION (City, town or county) (State): Berlin, Md.

24. FUNERAL DIRECTOR: Samuel Savage ADDRESS: New Church, Va.
25a. REC'D BY REGISTRAR DATE: APR 15 1966
25b. REGISTRAR'S SIGNATURE: Charles Grogg

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06118 — 06114

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Wicomico — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Md. — b. COUNTY: Worcester
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Stockton
   d. STREET ADDRESS: R.F.D. 2 Box 93
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ella — Middle: M. — Last: Collins

4. DATE OF DEATH: Month: April — Day: 2 — Year: 19 66

5. SEX: Female — 6. COLOR OR RACE: Negro — 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ — 8. DATE OF BIRTH: Aug. 11, 1901 — 9. AGE (In years last Birthday): 64 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Domestic

11. BIRTHPLACE (County & State, or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Truitt

14. MOTHER'S MAIDEN NAME: Estella ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service): —

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Ethel Mason — Address: 7 Church St. Pocomoke Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 12h.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Myocardial Infarction — :
DUE TO (c): Asteriosclerosis — Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) —

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan, 19 66, to Apr., 19 66, that (I) (we) last saw the deceased alive on 2 April 19 66, and that death occurred at 9:05 M, from the causes and on the date stated above.

22a. SIGNATURE: David Raft — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 4-4-66

22c. PHYSICIAN'S NAME (Type): DAVID RAFAT — 22d. ADDRESS: Snow Hill Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 4-9-66 — 23c. NAME OF CEMETERY OR CREMATORY: St. Paul Cem. — 23d. LOCATION (City, town or county) (State): Stockton, Md.

24. FUNERAL DIRECTOR: Samuel Layfield — ADDRESS: New Church, Va.

25a. REC'D BY REGISTRAR — DATE: APR 7 1966 — 25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
15M 4-64

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06119

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06115

1. PLACE OF DEATH
a. COUNTY: Wicomico Co. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fruitland, Md.
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address):

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE: Md.
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Berlin
d. STREET ADDRESS: P.O. Box 143
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

23-2

3. NAME OF DECEASED (Type or print): First Mary Middle Louise Lost Collins

4. DATE OF DEATH: Month 4 Day 9 Year 1966

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9/1/42

9. AGE (In years last birthday): 23 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Newark, Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Harold H. Collins

14. MOTHER'S MAIDEN NAME: Dora Whitbeck

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: Harold Collins Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Compound fracture skull, Crushed chest
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

8254

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.): Automobile accident

20c. TIME OF INJURY Month, Day, Yeor Hour a.m. p.m.: 5:30 P.m. 4/9/66 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): St. Lukes Road

20f. (City or town) Fruitland, Md. (County) Wicomico (State)

21. I certify that I taak charge of the remains described abave, held an Autopsy ☐, Inspectian ☒, Inquiry ☐, and in my opinian death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Philip A. Insley M.D.

EXAMINER'S NAME (Type): Philip A. Insley

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county): Salisbury, Maryland

22. DATE SIGNED: 4/11/66

23a. BURIAL, ~~CREMATION~~, REMOVAL (Specify)

23b. DATE THEREOF: 4/14/66

23c. NAME OF CEMETERY OR CREMATORY: Evergreen Cem.

23d. LOCATION (City or Town): Berlin (County) Md. (State)

24. FUNERAL DIRECTOR: Baker M. West ADDRESS: Salisbury

25a. FILED BY REGISTRAR ON DATE: APR 14 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06120 06116

FOR STATE HEALTH DEPT. USE

1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any deloy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fruitland
c. LENGTH OF STAY IN 1b: 4yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: Route 3 Shaw R.F.D.
e. IS RESIDENCE ON A FARM? YES ☑ NO ☐

3. NAME OF DECEASED (Type or print): First Thomas — Middle Jefferson — Last Corbin
4. DATE OF DEATH: Month 4 — Day 9 — Year 1966
5. SEX: Male
6. COLOR OR RACE: C
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8/24/43
9. AGE (In years last birthday): 23 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13. FATHER'S NAME: Earnest Corbin
14. MOTHER'S MAIDEN NAME: Nettie Taylor
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service):
16. SOCIAL SECURITY NO.: 216-40-3466
17. INFORMANT: Earndeaner Corbin — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Fracture skull — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last.
(b):
DUE TO
(c):
8254

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o): Fractured jaw, Lacerations legs
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.): Automobile accident
20c. TIME OF INJURY Month, Day, Yeor Hour o.m. p.m.: 5:30 P.m. 4/9/66 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): St. Lukes Road,
20f. (City or town) (County) (State): Fruitland, Wicomico, Md.

21. I certify thot I took charge of the remoins described obave, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined monner ☐

ACTUAL SIGNATURE: Philip A. Insley M.D.
EXAMINER'S NAME (Type): Philip A. Insley
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county): Salisbury, Maryland
22. DATE SIGNED: 4/11/66

23a. BURIAL, CREMATION, ~~REMOVAL~~ (Specify)
23b. DATE THEREOF: 4/16/66
23c. NAME OF CEMETERY OR CREMATORY: Taylor Gate Cem.
23d. LOCATION (City or Town) (County) (State): Snow Hill Md.
24. FUNERAL DIRECTOR: Booker M. West — ADDRESS: Salisbury
25a. REC'D BY REGISTRAR DATE: APR 14 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15ME (5) 6M 1/66

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06121 06117

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 822 Days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Deer's Head State Hospital, Salisbury, Md.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pocomoke — 23-2
d. STREET ADDRESS: 335 Winter Quarters Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Olive — Middle: Craig — Last: Cropper
4. DATE OF DEATH: Month: 4 — Day: 9 — Year: 19 66
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Aug. 21, 1885
9. AGE (In years last birthday): 80 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: --
11. BIRTHPLACE (County & State, or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: W. F. Craig
14. MOTHER'S MAIDEN NAME: Elizabeth Reed
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service): --
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs Ruth C. Bishop — Address: Pocomoke City, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Status post fracture of right femur with insertion of Austin-Moore prosthesis. — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs
962x
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Pneumonia, right lung — 10 days
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1/8, 1964 A. to 4/9, 19 66, that (I) (we) last saw the deceased alive on 4/9 19 66, and that death occurred at 6:45 M, from the causes and on the date stated above.

22a. SIGNATURE: L. V. Maldve — M.O. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 4/11/66
22c. PHYSICIAN'S NAME (Type): L. V. Maldve, M. D.
22d. ADDRESS: Deer's Head State Hospital, Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 4-11-1966
23c. NAME OF CEMETERY OR CREMATORY: Rehoboth Baptist
23d. LOCATION (City, town or county) (State): Rehoboth, Maryland
24. FUNERAL DIRECTOR: Robert N. Watson — ADDRESS: Pocomoke City, Md.
25a. REC'D BY REGISTRAR DATE: APR 13 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

1

FOR STATE HEALTH DEPT.

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06122

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06118

1. PLACE OF DEATH
   a. COUNTY: Wicomico — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Tyaskin
   c. LENGTH OF STAY IN 1b: Lifetime
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: Md. — b. COUNTY: Wicomico
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Tyaskin 22-1
   d. STREET ADDRESS
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First George — Middle — Last Dashield

4. DATE OF DEATH: Month April — Day 9 — Year 1966

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 8/9/1896

9. AGE (In years last birthday): 69 yrs.
   IF UNDER 1 YEAR: Months — Days
   IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Noah Dashield

14. MOTHER'S MAIDEN NAME: Sally Green

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
    (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 212-14-4052

17. INFORMANT: Elizabeth Dashield — Address: Tyaskin, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
    PART I. DEATH WAS CAUSED BY:
    IMMEDIATE CAUSE (a): 3rd degree burns of 50% of body
    DUE TO
    (b):
    DUE TO
    (c):
    Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
    9160
    INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Fire at home

20c. TIME OF INJURY Month, Day, Year, Hour o.m. p.m.: 4/9/1966

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) (County) (State): Tyaskin, Wicomico, Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Philip A. Insley M.D.

EXAMINER'S NAME (Type): Philip A. Insley

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county): Salisbury, Md.

22. DATE SIGNED: 4/12/66

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/11/66

23c. NAME OF CEMETERY OR CREMATORY: Whitehaven Cemetery

23d. LOCATION (City or Town) (County) (State): Whitehaven, Wicomico, Md.

24. FUNERAL DIRECTOR: C. M. Jesdale — ADDRESS: Bivalve, Md.

25a. FILED BY REGISTRAR DATE: APR 20 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15ME (5) 6M 1/66

1

M

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06123

CERTIFICATE OF DEATH

06119

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Wicomico
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
   c. LENGTH OF STAY IN 1b: 19 Days
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Deer's Head State Hospital, Salisbury, Md.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Wicomico
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Quantico
   d. STREET ADDRESS: 221
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Minnie; Middle: ; Last: Dashiell

4. DATE OF DEATH: Month: 4; Day: 9; Year: 19 66

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12-27-1912

9. AGE (In years last birthday): 53 yrs.
   IF UNDER 1 YEAR: Months ; Days
   IF UNDER 24 HRS.: Hours ; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (County & State, or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Josiah J. Bates

14. MOTHER'S MAIDEN NAME: Georgie Price

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 212-14-4497

17. INFORMANT: Leonard Westville — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypertensive cardiorenal disease with uremia — INTERVAL BETWEEN ONSET AND DEATH: Years

4427

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year; Hour a.m. p.m.; 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 3/21, 19 66, to 4/9, 19 66, that (I) (we) last saw the deceased alive on 4/9/ 19 66, and that death occurred at 6:10 P.M., from the causes and on the date stated above.

22a. SIGNATURE: W. Maldve, M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 4/11/66

22c. PHYSICIAN'S NAME (Type): L. V. Maldve, M. D.

22d. ADDRESS: Deer's Head State Hospital, Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/12/66

23c. NAME OF CEMETERY OR CREMATORY: Family Lot

23d. LOCATION (City, town or county) (State): Head-of-the-Creek, Md.

24. FUNERAL DIRECTOR: Baker M. West — ADDRESS: Salisbury, Md.

25a. REC'D BY REGISTRAR DATE: APR 14 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20M 1/65

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06124 (M) 06120

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Peninsula General

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury 22-1
d. STREET ADDRESS: 206 Gordy Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Gertrude — Middle: May — Last: Davis

4. DATE OF DEATH: Month: April — Day: 29 — Year: 1966

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Dec. 3/1895

9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months: 4 Days: 26
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Shirt factory employee

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Phila, Pa.

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: James Godwin

14. MOTHER'S MAIDEN NAME: Annie Kate Campbell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mr. Herman E. (Cowboy) Davis- Son
Address: 206 Gordy Rd. Salisbury, Md. 2-1897

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Chronic myeloid Leukemia — INTERVAL BETWEEN ONSET AND DEATH: Unknown

2041

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from 4-3, 1966, to 4-29, 1966, that (I) ~~(we)~~ last saw the deceased alive on 4-28 1966, and that death occurred at 2:34 A M, from the causes and on the date stated above.

22a. SIGNATURE: George H. Henning — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: Apr. 29/1966

22c. PHYSICIAN'S NAME (Type): Dr. George H. Henning

22d. ADDRESS: Salisbury Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: May 2/1966

23c. NAME OF CEMETERY OR CREMATORY: Springhill Mem. Gardens

23d. LOCATION (City, town or county) (State): Salisbury, Maryland

24. FUNERAL DIRECTOR — ADDRESS: HOLLOWAY & COMPANY SALISBURY, MARYLAND

25a. REC'D BY REGISTRAR DATE: MAY 2 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06125 06121

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH — e. COUNTY: Wicomico — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Wicomico
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
   d. STREET ADDRESS: 410 Hastings St
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Coy — Middle: Ellis — Last: DEASON
4. DATE OF DEATH: Month: April — Day: 15 — Year: 1966
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jan. 18, 1917
9. AGE (In years last birthday): 49 yrs. — IF UNDER 1 YEAR: Months: 2 Days: 27 — IF UNDER 24 HRS.: Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer (Operator of Equip)
10b. KIND OF BUSINESS OR INDUSTRY: City
11. BIRTHPLACE (County & State, or Foreign country): Alabama
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: James Deason
14. MOTHER'S MAIDEN NAME: Charity Rachel Mize
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): YES (If yes give war or dates of service): W.W.#II
16. SOCIAL SECURITY NO.: 163-18-5705
17. INFORMANT — Address: Mrs. Laura Ethel Deason (Wife) 410 Hastings St. Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Sudden
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
   DUE TO (b): Coronary Artery Disease — 5-4 years
   DUE TO (c):
   4201
   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(c): Diabetes Mellitus — 15 or more years
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
2Da. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
2Dc. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19
2Dd. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Febrile, 1966, to April 15, 1966; that (I) (we) last saw the deceased alive on April 14, 1966, and that death occurred at 5:10 P.M., from the causes and on the date stated above.

22a. SIGNATURE: G. Herbert Sembly M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 4/15/66
22c. PHYSICIAN'S NAME (Type): G. Herbert Sembly
22d. ADDRESS: Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Apr. 18/66
23c. NAME OF CEMETERY OR CREMATORY: Wicomico Memorial Park
23d. LOCATION (City, town or county) (State): Salisbury, Maryland
24. FUNERAL DIRECTOR — ADDRESS: HOLLOWAY & COMPANY SALISBURY, MARYLAND
25a. REC'D BY REGISTRAR DATE: APR 20 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06126 06122

1. PLACE OF DEATH
a. COUNTY: Wicomico MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 927 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural-Pocomoke City 23-2
d. STREET ADDRESS: R.F.D. 3
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Clarence	B.	Denston	Apr.	28	19 66

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	[X] / [ ] / [ ] / [ ]	Feb. 2, 1894	72 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer	Farming	Worcester County, Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Frank B. Denston	Annie Carter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No --	217-30-8736	Beverly F. Denston, Pocomoke City, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Bilateral bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: days

491X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Parkinson's disease

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work [ ] Not While at work [ ]	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that XX (this hospital) attended the deceased from Oct. 14, 1963, to Apr. 28, 1966, that XX (we) last saw the deceased alive on Apr. 28 19 66, and that death occurred at 4:05 A.M., from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [X] — 22b. DATE SIGNED: 4/28/66

22c. PHYSICIAN'S NAME (Type): C.F.Gutierrez-Garrido, M.D. — 22d. ADDRESS: Deer's Head Hospital; Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
Burial	5-1-1966	Salem Methodist	Pocomoke City, Maryland

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Robert H. Watson	Pocomoke City, Md.	MAY 3 1966	J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06127 06123

Items 2,8,9 Film 6376 24766 mh

1. PLACE OF DEATH
   a. COUNTY: WICOMICO — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FRUITLAND
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: MARYLAND
   b. COUNTY: WICOMICO
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fruitland
   d. STREET ADDRESS: 22-1
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ERNEST Middle F. Last DISHAROON

4. DATE OF DEATH: Month APRIL Day 28 Year 1966

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: May 17, 1873

9. AGE (In years last birthday): 92 yrs.
   IF UNDER 1 YEAR: Months / Days
   IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED

10b. KIND OF BUSINESS OR INDUSTRY: SAW MILL OPERATED

11. BIRTHPLACE (County & State, or foreign country): EDEN, MARYLAND R.F.D.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: FRANKLIN DISHAROON

14. MOTHER'S MAIDEN NAME: ELIZABETH CAREY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac decompensation — INTERVAL BETWEEN ONSET AND DEATH: 3 days

4200

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) Arteriosclerotic heart disease — 4 years

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from 2-22, 1966, to 4-28, 1966, that (I) (we) last saw the deceased alive on 4-28 1966, and that death occurred at 7:35 M, from the causes and on the date stated above.

22a. SIGNATURE: Robert R. Tilute, Jr. M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4-30-66

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 5/1/1966

23c. NAME OF CEMETERY OR CREMATORY: ST.JOHN CEMETERY

23d. LOCATION (City, town or county) (State): FRUITLAND, MARYLAND

24. FUNERAL DIRECTOR — ADDRESS: LEVIN R. WILSON PRINCESS ANNE, MD.

25a. REC'D BY REGISTRAR DATE: MAY 2 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
15M 4-64

Item 20 Film G3756 4/25/66 [illegible]

1 FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06128

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06124

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): St. Luke's Road
c. LENGTH OF STAY IN 1b: Fruitland
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): St. Luke's Road

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Parsonburg
d. STREET ADDRESS: Rt. #1
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Alfred; Middle: ; Last: Duffy

4. DATE OF DEATH: Month: 4; Day: 9; Year: 1966

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: 11-9-27

9. AGE (In years last birthday): 38 yrs. IF UNDER 1 YEAR: Months: ; Days: ; IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Somerset

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Alfred Graham

14. MOTHER'S MAIDEN NAME: Lillian Duffy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown):
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Sarah Duffy Address: Rt #1 Parsonburg, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Fractured skull
8234
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. EXTERNAL CAUSE WAS PRIMARY [X] or CONTRIBUTING [ ] CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Was riding in auto. that ran off road & struck tree

20c. TIME OF INJURY Month, Day, Year: Hour 5:20 a.m. p.m. 4-9 1966

20d. INJURY OCCURRED While at work [ ] Not While at work [X]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): St Lukes Rd.

20f. (City or town) (County) (State): Fruitland Wicomico Md

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [ ], and in my opinion death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Phillip A Insley M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

EXAMINER'S NAME (Type): Phillip A Insley

Address (Street, city, town, or county):

22. DATE SIGNED: 4-12-66

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4-13-66

23c. NAME OF CEMETERY OR CREMATORY: John Westley

23d. LOCATION (City, town or county) (State): Princess Anne Md.

24. FUNERAL DIRECTOR: Loretta B. Jolley ADDRESS: Jersey Rd, Salis.

25a. REC'D BY REGISTRAR DATE: APR 18 1966

25b. REGISTRAR'S SIGNATURE: J Charles Judge

VR A1SME (5) 5M 1/65 BP

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06129 — 06125

1 — M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: Wicomico — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) — a. STATE: Md. — b. COUNTY: Worcester
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pocomoke City 23-2
   d. STREET ADDRESS: R.F.D. 1, Box 208
   e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Idella — Middle: Bertie — Last: Finney

4. DATE OF DEATH: Month: Cyrril — Day: 23 — Year: 1966

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb. 7, 1909

9. AGE (In years last birthday): 57 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: Domestic

11. BIRTHPLACE (County & State, or foreign country): Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Cropper

14. MOTHER'S MAIDEN NAME: Nora Pettit

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: None.

17. INFORMANT: Jacob Finney — Address: Pocomoke City, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Generalized Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH

1538

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Carcinoma of Colon — 2-3 yrs

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4-15, 1966, to 4-23, 1966, that (I) (we) last saw the deceased alive on 4-23, 1966, and that death occurred at 7:15 P.M., from the causes and on the date stated above.

22a. SIGNATURE: H. A. Briele — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 4-24-66

22c. PHYSICIAN'S NAME (Type): H. A. Briele — 22d. ADDRESS: Medical Center Salisbury Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 4-28-66 — 23c. NAME OF CEMETERY OR CREMATORY: Tindley Chapel Cem. — 23d. LOCATION (City, town or county) (State): Pocomoke City Md.

24. FUNERAL DIRECTOR: Samuel Savage — ADDRESS: New Church, Va.

25a. REC'D BY REGISTRAR — DATE: APR 28 1966 — 25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
15M 4-64

1 (M)

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS; 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06130

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06126

1. PLACE OF DEATH
a. COUNTY: Wicomico
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Pen.Gen. Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 311½ Race St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LILLIAN Middle MARY Last FITZGERALD

4. DATE OF DEATH: Month APRIL Day 1st Year 1966

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Aug. 24/1906

9. AGE (In years last birthday): 59 yrs.
IF UNDER 1 YEAR: Months 7 Days 7
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House work at home

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Salisbury, Maryland

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Elijah Campbell

14. MOTHER'S MAIDEN NAME: Nora Elizabeth Rittenhouse

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: Mrs. Louise Kelly (Sister-In-Law) 221 E. College Ave Salisbury, Md. 21801

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma Edema — INTERVAL BETWEEN ONSET AND DEATH: 2 mo

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Atelectasis & Pulmonary tumor — 1 mo
DUE TO (c):

307 ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Fx. Femur

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☑ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year: 3-30-66 Hour a.m. p.m.

20d. INJURY OCCURRED While at work ☐ Not While at work ☑

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):

20f. (City or town) Salisbury (County) Wicomico (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☑, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): Dr. Earl L. Royer

Address (Street, city, town, or county): 409 Camden Ave. Salisbury, Md

22. DATE SIGNED: April 2 /1966

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Apr. 5/66

23c. NAME OF CEMETERY OR CREMATORY: Bethel Church Cem. (Walston)

23d. LOCATION (City, town or county) (State): Salisbury, Maryland

24. FUNERAL DIRECTOR: HOLLOWAY & COMPANY ADDRESS: SALISBURY, MARYLAND

25a. REC'D BY REGISTRAR DATE: APR 6 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AISME (5) 5M 1/65

___ x ____ x ___ x

_____ x

Item 18 Film G376 5/1/66 [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06131

Worcester 23-127

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY: Wicomico — MARYLAND	2. USUAL RESIDENCE (Where deceased lived, If institution, Residence Before admission) a. STATE: Maryland — b. COUNTY: XXXXXXXX
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury — c. LENGTH OF STAY IN 1b:	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): XXXX Bishopville (Worcester 66)
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Peninsula General Hospital	d. STREET ADDRESS: 23-2 — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Celia	C.	Fleetwood	April	13	1966

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White		March 3, 1895	71 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Robbins Cropper	Annie Mumford

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown)	(If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
XX	XX	214-32-0814	Matt Fleetwood	Bishopville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration of Stomach contents — INTERVAL BETWEEN ONSET AND DEATH:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) Septicemia due to obstruction of right kidney — 6 weeks

DUE TO (c) Hiatal hernia — 4-6 wks.

5614

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Hiatal hernia repaired 4/5/66

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 3/1, 19 66, to 4/13, 19 66, that (I) (we) last saw the deceased alive on 4/1, 19 ____, and that death occurred at 3:45 AM, from the causes and on the date stated above.

22a. SIGNATURE	M.D. ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐	22b. DATE SIGNED
H.P. Briele		4/15/66

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
H.P. Briele	Medical Center Salisbury, md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
Burial	4/16/66	Odd Fellows	Bishopville, Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Peter Whaley	Selbyville, Del.	APR 18 1966	J. Charles Judge

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06132 06128

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Wicomico
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   STATE: Maryland
   b. COUNTY: Somerset
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Manokin
   d. STREET ADDRESS:
   e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Edward; Middle: L.; Last: Fontaine

4. DATE OF DEATH: Month: April; Day: 22; Year: 1966

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 30 1916

9. AGE (In years last birthday): 49 yrs.
   IF UNDER 1 YEAR: Months / Days
   IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Office Work

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Dayton Wash

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Harry Fontaine

14. MOTHER'S MAIDEN NAME: Sarah Longford

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown):
    (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Harry Fontaine Address: Manokin Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Hypovolemic Shock.	6 hrs.
DUE TO (b)	Bleeding esophageal varices.	8 hrs
DUE TO (c)	Cirrhosis of liver.	Years

5810

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4/18, 1966, to 4/22, 1966, that (I) (we) last saw the deceased alive on 4/21, 1966, and that death occurred at 2:55 P.M., from the causes and on the date stated above.

22a. SIGNATURE: [signature]

M.O. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/24/66

23c. NAME OF CEMETERY OR CREMATORY: St. Andrew Cemetery

23d. LOCATION (City, town or county) (State): Princess Anne Md

24. FUNERAL DIRECTOR: Leon R. Wilson

ADDRESS: Princess Anne Md

25a. REC'D BY REGISTRAR DATE: APR 27 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
15M 4-64

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06133 — 06129

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Delaware
b. COUNTY: Sussex
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frankford 46-3
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Lester — Middle: W. — Last: Franklin

4. DATE OF DEATH: Month: April — Day: 24 — Year: 1966

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 6-20-1906

9. AGE (In years last birthday): 59 yrs.
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): State Employee

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Delaware

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: George W. Franklin

14. MOTHER'S MAIDEN NAME: Annie D. Baker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown):
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 222-09-1253

17. INFORMANT: Helen Franklin, Address: Frankford, Del.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Heart Failure — INTERVAL BETWEEN ONSET AND DEATH:

4221

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): ASCVD & Rheu. Ht Dis — years

DUE TO (c): Aortic Stenosis & Mitral Insuff. — years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)**

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4-21, 1966, to 4-24, 1966, that (I) (we) last saw the deceased alive on 4-24 1966, and that death occurred at 12:55 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Joseph C. FitzGerald — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4-24-66

22c. PHYSICIAN'S NAME (Type):

22d. ADDRESS: Medical Center Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4-27-66

23c. NAME OF CEMETERY OR CREMATORY: Roxana Cem.

23d. LOCATION (City, town or county) (State): Roxana, Del.

24. FUNERAL DIRECTOR: A. Douglas Melson — **ADDRESS**: Frankford, Delaware

25a. REC'D BY REGISTRAR DATE: MAY 5 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06134 06130

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
   a. COUNTY: Wicomico — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
   c. LENGTH OF STAY IN 1b: 3 Wks.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Wicomico
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Willards
   d. STREET ADDRESS: Main St.,
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First GLADYS — Middle RAYNE — Last FULLER

4. DATE OF DEATH: Month 4 — Day 19 — Year 1966

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Sept. 29, 1899

9. AGE (In years last birthday): 66 yrs.
   IF UNDER 1 YEAR: Months — Days
   IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): School Teacher

10b. KIND OF BUSINESS OR INDUSTRY: Teacher

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Noah T. Rayne

14. MOTHER'S MAIDEN NAME: Addie Duncan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give wor or dotes of service)

16. SOCIAL SECURITY NO.: 216-26-6974

17. INFORMANT: Mrs. June F. Jones, Willards, Maryland — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Chondrosarcoma, left ant. rib with metastases
   DUE TO (b): to both lungs
   DUE TO (c):
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
   1963
   INTERVAL BETWEEN ONSET AND DEATH: Unknown (Appx. 3 mos.)

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 4/2, 1966, to 4/19, 1966, that (I) (we) last saw the deceased alive on 4/19 19 66, and that death occurred at 12:10 P.M. from causes and on the date stated above.

22a. SIGNATURE: David J. Gilmore M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): David J. Gilmore, M.D.

22d. ADDRESS: MEDICAL CTR., SALISBURY, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4-21-1966

23c. NAME OF CEMETERY OR CREMATORY: New Hope Cemetery

23d. LOCATION (City or Town) (County) (State): New Hope, Maryland

24. FUNERAL DIRECTOR: Hill Funeral Home Salisbury, Maryland — ADDRESS: Norman T. Baker

25a. REC'D BY REGISTRAR: DATE APR 26 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06135 06131

1. PLACE OF DEATH
a. COUNTY: Wicomico
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 56 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 124 First Street
d. STREET ADDRESS: Salisbury, Maryland
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Catherine Middle: Young Last: Gordy
4. DATE OF DEATH: Month: 4 Day: 28 Year: 19 66
5. SEX: Female
6. COLOR OR RACE: N
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Dec. 27, 1925
9. AGE (In years last birthday): 40 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY: Waitress
11. BIRTHPLACE (County & State, or foreign country): Wicomico
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Bodie Young
14. MOTHER'S MAIDEN NAME: Pearl Farlow
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 212-14 4955
17. INFORMANT: Hospital Records Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 4 wks.
454X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Cerebro-Vascular Accident due Thrombosis of Left Carotid Artery
DUE TO (c): [redacted] — 4 mos.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 3/8/66, 19__, to 4/28/66, 19__, that (I) (we) last saw the deceased alive on 4/28/66 19__, and that death occurred at 5:20 M, from the causes and on the date stated above.

22a. SIGNATURE: R. Gore M.D. M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐
22b. DATE SIGNED: 4-29-66
22c. PHYSICIAN'S NAME (Type): R. Gore, M.D.
22d. ADDRESS: Box 671, Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL, (Specify): Burial
23b. DATE THEREOF: 5-2-1966
23c. NAME OF CEMETERY OR CREMATORY: Green Acres Mem. Pk.
23d. LOCATION (City, town or county) (State): Salisbury, Md.
24. FUNERAL DIRECTOR: Loretta B. Jolley ADDRESS
25a. REC'D BY REGISTRAR DATE: MAY 2 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06136 — 06132

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: Lifetime
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Tyaskin
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Sollers — Middle: Wilson — Last: Graham

4. DATE OF DEATH: Month: April — Day: 12 — Year: 1966

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: 2/21/1898

9. AGE (In years last birthday): 68 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Own Farm

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Henry Graham

14. MOTHER'S MAIDEN NAME: Annie Langrall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): —
(If yes give war or dates of service): —

16. SOCIAL SECURITY NO.: 212-16-7139

17. INFORMANT — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: Hrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Coronary Arteriosclerosis. — Years
DUE TO (c): 4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Chronic Bronchitis & Emphysema.

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4/12, 1966, to 4/12, 1966; that (I) (we) last saw the deceased alive on 4/12 1966, and that death occurred at 5:11a M, from the causes and on the date stated above.

22a. SIGNATURE: [signature]
M.D. ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED: 4/13/66

22c. PHYSICIAN'S NAME (Type): O.J. Burton
22d. ADDRESS: Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 4/14/66
23c. NAME OF CEMETERY OR CREMATORY: St. Mary's Cem.
23d. LOCATION (City, town or county) (State): Tyaskin, Md.

24. FUNERAL DIRECTOR: C. Impastato — ADDRESS: Bivalve, Md.
25a. REC'D BY REGISTRAR DATE: APR 14 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06137 Item #6 - 2d no. 375-44466 MB 06133

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Wicomico
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
   c. LENGTH OF STAY IN 1b: MARYLAND
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Delaware
   b. COUNTY: Sussex
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Millsboro 46-3
   d. STREET ADDRESS: RD1 BOX 83
   e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: (Americus) Albert; Middle: ; Last: Harmon

4. DATE OF DEATH: Month: April; Day: 1; Year: 1966

5. SEX: Male

6. COLOR OR RACE: AMERIND

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: 31 AUG 1909

9. AGE (In years last birthday): 56 yrs.
   IF UNDER 1 YEAR: Months: ; Days: ; IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): POULTRY & FARMING

10b. KIND OF BUSINESS OR INDUSTRY: AGRICULTURE

11. BIRTHPLACE (County & State, or foreign country): Atlantic Co, NJ.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Harvey H. Harmon

14. MOTHER'S MAIDEN NAME: Sally Jackson (Harmon)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): ✓ (If yes give war or dates of service): ✓

16. SOCIAL SECURITY NO.: 150-09-5235

17. INFORMANT: Anna M Harmon, Millsboro Dela

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Rupture of Myocardium

4201

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 10 days.

DUE TO (c): Coronary artery atherosclerosis & arteriosclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Post op. cholecystectomy

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year; Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 3-1, 1966, to 4-1, 1966, that (I) (we) last saw the deceased alive on 4-1, 1966, and that death occurred at 9:10 AM, from the causes and on the date stated above.

22a. SIGNATURE: Joseph C. Fitzgerald — M.D. ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS: Medical Center Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 6 APR 66

23c. NAME OF CEMETERY OR CREMATORY: Indian Mission Cem.

23d. LOCATION (City, town or county) (State): Harbeson Dela

24. FUNERAL DIRECTOR: R.F. Dodd — ADDRESS: Georgetown Dela.

25a. REC'D BY REGISTRAR DATE: APR 11 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06138 06134

1. PLACE OF DEATH
a. COUNTY: WICOMICO — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Springhill Sanitarkum

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: WICOMICO
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 406 Poplar Hill Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ABBIE — Middle ROSE — Last HAYMAN
4. DATE OF DEATH: Month APRIL — Day 27 — Year 1966
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Oct.20/1872
9. AGE (In years last birthday): 93 yrs.
IF UNDER 1 YEAR: Months 6 — Days 7 — IF UNDER 24 HRS.: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (County & State, or foreign country): Onancock, Virginia
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: Thomas Johnson
14. MOTHER'S MAIDEN NAME: Margaret Jane Fitzgerald
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 220-44-9733
17. INFORMANT: Mr. Albin A. Hayman (Son) Address: 415 Forest Lane Salisbury, Maryland 21801

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Insufficiency with Stroke Sets — INTERVAL BETWEEN ONSET AND DEATH: 4days
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. 334x
DUE TO (b): generalized arteriosclerosis — ?
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Dehydration
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): N/A
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from May Apr., 1960, to April 27, 1966, that (I) (~~we~~) last saw the deceased alive on April 23 1966, and that death occurred at 11 20 AM, from the causes and on the date stated above.

22a. SIGNATURE: Robert T. Adkins M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Apr. 28 /1966
22c. PHYSICIAN'S NAME (Type): Dr. Robert T. Adkins
22d. ADDRESS: Fruitland, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Apr.30/1966
23c. NAME OF CEMETERY OR CREMATORY: Parsonsburg Cemetery
23d. LOCATION (City, town or county) (State): Parsonsburg, Maryland

24. FUNERAL DIRECTOR: HOLLOWAY & COMPANY — ADDRESS: SALISBURY, MARYLAND
25a. REC'D BY REGISTRAR DATE: MAY 2 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06139 06135

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: Wicomico — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: Worcester
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pocomoke 23-2
   d. STREET ADDRESS: 108 Cherry St.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: H. — Last: Hearne

4. DATE OF DEATH: Month: April — Day: 1 — Year: 1966

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Sept. 9 1909

9. AGE (In years last birthday): 56 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Contractor

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (County & State, or foreign country): New York

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William G. Hearne

14. MOTHER'S MAIDEN NAME: Emily Madison

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
    (If yes give war or dates of service): —

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Lt. John W. Hearne, U.S. Army

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
    PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: Unknown
    4200
    Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
    DUE TO (b):
    DUE TO (c):

    PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 3-16, 1966 to 4-1, 1966 that (I) (we) last saw the deceased alive on 4-1, 1966, and that death occurred at 6:45 P.M., from the causes and on the date stated above.

22a. SIGNATURE: W. Hearne Jr. M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4-1-66

22c. PHYSICIAN'S NAME (Type):

22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: April 4, 1966

23c. NAME OF CEMETERY OR CREMATORY: Christian Cemetery

23d. LOCATION (City, town or county) (State): Snow Hill Maryland

24. FUNERAL DIRECTOR: Forman F. Lemmis — ADDRESS: Snow Hill, Md.

25a. REC'D BY REGISTRAR DATE: APR 5 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06140 (M) 06136

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Snow Hill
d. STREET ADDRESS: Martin St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: Grover — Last: Hill, Sr.

4. DATE OF DEATH: Month: April — Day: 30 — Year: 1966

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: June 30 1922

9. AGE (In years last birthday): 43 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Town Employee

11. BIRTHPLACE (County & State, or foreign country): Snow Hill, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Grover Hill

14. MOTHER'S MAIDEN NAME: Mary Hickman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Eva Mae Selloway, Snow Hill, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hepatic Coma — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs
5811
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Laennec's Cirrhosis — 4 years
DUE TO (c): Acute & Chronic Alcoholism — years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): AI Bleeding

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan, 1965, to Apr., 1966, that (I) (we) last saw the deceased alive on Apr. 30 1966, and that death occurred at 4A M, from the causes and on the date stated above.

22a. SIGNATURE: David Rafat M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED:

22c. PHYSICIAN'S NAME (Type): DAVID RAFAT

22d. ADDRESS: Snow Hill, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: May 2, 1966

23c. NAME OF CEMETERY ~~OR CREMATORY~~: Whatcoat Methodist

23d. LOCATION (City, town or county) (State): Snow Hill Md.

24. FUNERAL DIRECTOR — ADDRESS: Norman F. Dennis, Snow Hill, Md.

25a. REC'D BY REGISTRAR DATE: MAY 3 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06141 06137

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WICOMICO
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): DELMAR
d. STREET ADDRESS: 906 E. STATE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARY Middle W Last Horsey

4. DATE OF DEATH: Month April Day 25 Year 1966

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 2-1-1891

9. AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): OWNER

10b. KIND OF BUSINESS OR INDUSTRY: LADIES STORE

11. BIRTHPLACE (County & State, or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: FRANKLIN WHEATLEY

14. MOTHER'S MAIDEN NAME: TAMSEY WILLIAMS.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 221-03-1139

17. INFORMANT: MAGGIE WHEATLEY Address: SHARPTOWN MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: Unknown
4200
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4-25, 1966 to 4-25, 1966, that (I) (we) last saw the deceased alive on 4-25 1966, and that death occurred at 6:57 M, from the causes and on the date stated above.

22a. SIGNATURE: William R. Wolf M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4-28-66

22c. PHYSICIAN'S NAME (Type):

22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 4-28-66

23c. NAME OF CEMETERY OR CREMATORY: ST STEPHENS

23d. LOCATION (City, town or county) (State): DELMAR - DEL

24. FUNERAL DIRECTOR: Charles W. Marvil ADDRESS: Delmar Del

25a. REC'D BY REGISTRAR: MAY 2 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06142 — 06138

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH**
   a. COUNTY: Wicomico — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bivalve
   c. LENGTH OF STAY IN 1b: Lifetime
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): —

2. **USUAL RESIDENCE** (Where deceased lived, If institution, Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Wicomico
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bivalve
   d. STREET ADDRESS: —
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. **NAME OF DECEASED** (Type or print): First: Rodgers — Middle: Clinton — Last: Horsman

4. **DATE OF DEATH**: Month: April — Day: 8 — Year: 1966

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 11/25/1889

9. AGE (In years last birthday): 76 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: George C. Horsman

14. MOTHER'S MAIDEN NAME: Julia Wainwright

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Lessie Horsman, Bivalve, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): CVA — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs

331X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Arteriosclerosis — 1 year

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 11/5, 1965, to 4/8, 1966, that (I) (we) last saw the deceased alive on 4/3, 1966, and that death occurred at 9 P.M. from the causes and on the date stated above.

22a. SIGNATURE: James J Kidney MD — M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4/11/66

22c. PHYSICIAN'S NAME (Type): James S. Kidney

22d. ADDRESS: Bivalve MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/13/66

23c. NAME OF CEMETERY OR CREMATORY: Bivalve Cemetery

23d. LOCATION (City, town or county) (State): Bivalve, Md.

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Conway Assoc. Bivalve, Md.

25a. REC'D BY REGISTRAR DATE: APR 14 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judy

VR A15 (4)
20M S-63

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06143 — 06139

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): PENINSULA GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Allen (Rural) — 22-1
d. STREET ADDRESS: - - - -
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: William — Middle: Clifford — Last: HUFFINGTON (CLIFFORD)
4. DATE OF DEATH: Month: April — Day: 23 — Year: 1966

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: Dec. 14/1891
9. AGE (In years last birthday): 74 yrs. — IF UNDER 1 YEAR: Months 4, Days 9 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (County & State, or foreign country): Allen, Maryland
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Jonathan Huffington
14. MOTHER'S MAIDEN NAME: Rosa Parker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) YES (If yes give war or dates of service) W.W.I (Army)
16. SOCIAL SECURITY NO.: 218-34-7704
17. INFORMANT: Dorothy H. Huffington (Wife) Address: Allen, Md. (PI-2-2378)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: Unknown
4201
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b): (Coronary Artery Thrombosis) — 1 hr
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Carcinoma of Prostate c metastases
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year: Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4/23, 19 66, to 4/23, 19 66, that (I) (we) last saw the deceased alive on 4/23 19 66, and that death occurred at 1 P M, from the causes and on the date stated above.

22a. SIGNATURE: David J. Gilmore — M.D. — ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED: Apr. 23 /1966
22c. PHYSICIAN'S NAME (Type): Dr. David J. Gilmore
22d. ADDRESS: Medical Center Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Apr. 26/1966
23c. NAME OF CEMETERY OR CREMATORY: Allen Cemetery
23d. LOCATION (City, town or county) (State): Allen, Maryland

24. FUNERAL DIRECTOR: HOLLOWAY & COMPANY — ADDRESS: SALISBURY, MARYLAND
25a. REC'D BY REGISTRAR DATE: APR 26 1966
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
15M 4-64

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06144

CERTIFICATE OF DEATH

06140

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Quantico
d. STREET ADDRESS: R.F.D.#1 Box 29
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

22-1

3. NAME OF DECEASED (Type or print): First: Sophia — Middle: E. — Last: Jackson

4. DATE OF DEATH: Month: April — Day: 15 — Year: 1966

5. SEX: Female

6. COLOR OR RACE: C.

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: June 30, 1892

9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Dashiell

14. MOTHER'S MAIDEN NAME: Sophia Dashiell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Cornelia Jackson — Address: Quantico Md. Box 29

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Arteriosclerosis with Hypostasis (advanced senility)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

3347

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
Arteriosclerosis Malnutrition

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

2Da. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. 19

2Dd. INJURY OCCURRED While at work ☐ Not While at work ☐

2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 3/30, 1966, to 4/15, 1966 that (I) (we) last saw the deceased alive on 4/14 1966, and that death occurred at 1:29 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Richard L. Gilmore — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/20/1966

23c. NAME OF CEMETERY OR CREMATORY: Church

23d. LOCATION (City, town or county) (State): Quantico Md.

24. FUNERAL DIRECTOR — ADDRESS: Clinton F. Stewart Salisbury Md.

25a. REC'D BY REGISTRAR DATE: APR 22 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06145 06141

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WORCESTER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BERLIN
d. STREET ADDRESS: BAY ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: CLINTON — Middle: ALFRED — Last: Jarman

4. DATE OF DEATH: Month: APRIL — Day: 20 — Year: 1966

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: JAN. 5, 1888

9. AGE (In years last birthday): 78 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED

10b. KIND OF BUSINESS OR INDUSTRY: FARMER

11. BIRTHPLACE (County & State, or foreign country): BERLIN MD

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: J. EDWARD JARMAN

14. MOTHER'S MAIDEN NAME: BESSIE COFFIN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: MR. J. EDWARD JARMAN JR. — Address: BERLIN MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 day
4200
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): Arteriosclerotic Heart Disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4-19, 1966, to 4-20, 1966 that (I) (we) last saw the deceased alive on 4-20 1966, and that death occurred at 10:45 AM, from the causes and on the date stated above.

22a. SIGNATURE: William R. Elliott M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4-20-66

22c. PHYSICIAN'S NAME (Type):

22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 4/20/66

23c. NAME OF CEMETERY OR CREMATORY: EVERGREEN

23d. LOCATION (City, town or county) (State): BERLIN Wor. Co MD

24. FUNERAL DIRECTOR: Anna A. Burbage — ADDRESS: Berlin MD

25a. REC'D BY REGISTRAR DATE: APR 25 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06146 06142

1. PLACE OF DEATH
a. COUNTY: WICOMICO MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): PENINSULA GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 200 Washington Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EDGAR Middle ALBERT Last JOHNSON
4. DATE OF DEATH: Month APRIL Day 16 Year 1966
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feb. 25/1892
9. AGE (In years last birthday): 74 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Owner-Operator-Masonary Contractor
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Sussex Co. Delaware
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: Robert P. Johnson
14. MOTHER'S MAIDEN NAME: Annie B. Joseph
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 220-01-8823
17. INFORMANT: Madelyn E. Donaway (Friend) Address: Pittsville, Md
Mrs. Virginia M. Johnson (Wife) R.D.#

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: 12 days
443X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Aortic Incompetence — 2 years
DUE TO (c): Cardiomegaly — Unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Passive Hepatic Congestion; Moderate Hepatomegaly; Hypertension
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): N/A
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Dec 23, 1967, to April 16, 1966, that (I) (we) last saw the deceased alive on April 16, 1966, and that death occurred at 11:25 AM, from the causes and on the date stated above.

22a. SIGNATURE: G. Herbert Sembly M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Apr. 19, 1966
22c. PHYSICIAN'S NAME (Type): Dr. G. Herbert Sembly
22d. ADDRESS: E. Church St. Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: April 20/1966
23c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery
23d. LOCATION (City, town or county) (State): Salisbury, Maryland

24. FUNERAL DIRECTOR: HOLLOWAY & COMPANY ADDRESS: SALISBURY, MARYLAND
25a. REC'D BY REGISTRAR DATE: APR 25 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

ALBERT

x

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06147

CERTIFICATE OF DEATH

06143

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: Adm in ID 3/10/66
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: R.D.#2 Springhill Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First ETHEL Middle LOUISE Last JOHNSON

4. DATE OF DEATH: Month APRIL Day 4 Year 1966

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 1/ 1900

9. AGE (In years last birthday): 65 yrs. IF UNDER 1 YEAR Months 9 Days 3 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (County & State, or foreign country): Mardela, Maryland

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: William R. Budd

14. MOTHER'S MAIDEN NAME: Mary Emily Jackson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mr. J. Quinton Johnson (Husband) Address: R.D.#2 Salisbury, Maryland 21801

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac arrest
5272
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): Patient undergoing surgery for emphysema & bronchiectasis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from ____, 19 __, to 4/4, 1966, that (I) (we) last saw the deceased alive on 4/4 1966, and that death occurred at 10 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Richard E. Hughes M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: Apr. 5 /1966

22c. PHYSICIAN'S NAME (Type): Dr. Richard Hughes

22d. ADDRESS: Medical Center Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Apr. 7/1966

23c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery

23d. LOCATION (City, town or county) (State): Salisbury, Maryland

24. FUNERAL DIRECTOR: HOLLOWAY & COMPANY ADDRESS: SALISBURY, MARYLAND

25a. REC'D BY REGISTRAR DATE: APR 11 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06148 (M) 06144

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH — e. COUNTY: Wicomico — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: Worcester
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pocomoke City
   d. STREET ADDRESS: 513 Bonneville Ave.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Wilbur — Middle: C. — Last: Johnson
4. DATE OF DEATH: Month: April — Day: 15 — Year: 1966
5. SEX: Male
6. COLOR OR RACE: NEGRO
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 15, 1907
9. AGE (In years last birthday): 58 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Delivering Groceries
11. BIRTHPLACE (County & State, or foreign country): Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Jacob Johnson
14. MOTHER'S MAIDEN NAME: Nettie Rue
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 218-12-1849
17. INFORMANT: Geraldine Hooper — Address: 5106 Wesley Ave. Balto. 7, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
   PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Uremia secondary to chronic nephritis — INTERVAL BETWEEN ONSET AND DEATH: 1 year
   592 X
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
   DUE TO (b): Hypertensive Vascular disease - Atherosclerosis
   DUE TO (c):
   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 3-10, 1966, to 4-15, 1966, that (I) (we) last saw the deceased alive on 4-15 1966, and that death occurred at 2 A M, from the causes and on the date stated above.

22a. SIGNATURE: Nabil F. Warsal M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 4-15-66
22c. PHYSICIAN'S NAME (Type): NABIL F. WARSAL
22d. ADDRESS: Peninsula General Hosp.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 4-19-66
23c. NAME OF CEMETERY OR CREMATORY: Unionville Cem.
23d. LOCATION (City, town or county) (State): Pocomoke City, Md.
24. FUNERAL DIRECTOR: Lewis Long — ADDRESS: New Church, Va.
25a. REC'D BY REGISTRAR — DATE: APR 19 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Jintzer

VR A15 (4)
15M 4-64

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06149

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06145

1. PLACE OF DEATH
   a. COUNTY: Wicomico — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
   c. LENGTH OF STAY IN 1b: D.O.A.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Wicomico
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
   d. STREET ADDRESS: 1135 S. Division St.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Elmer — Middle: Arcenus — Last: Kelly

4. DATE OF DEATH: Month: 4-20-66 — Day — Year: 19

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 28, 1948

9. AGE (In years last birthday): 17~~18~~ yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpet Installer

10b. KIND OF BUSINESS OR INDUSTRY: Rug & Carpet

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Elmer T. Kelly

14. MOTHER'S MAIDEN NAME: Mary A. Bull

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 218-48-7978

17. INFORMANT: Mrs Nancy Kelly, Address: 1135 S. Division St. Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Fractured cervical spine — INTERVAL BETWEEN ONSET AND DEATH: Sudden

8160

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

2Da. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): Passenger in truck involved in collision with 2nd truck

20c. TIME OF INJURY Month, Day, Year Hour e.m.: 7:45 A.M. 4-20-66

2Dd. INJURY OCCURRED While at work ☒ Not While at work ☐

2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Rt. 13

20f. (City or town) (County) (State): Westover Somerset Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22. DATE SIGNED: 4-20-66

EXAMINER'S NAME (Type): Earl L. Royer, M.D.

Address (Street, city, town, or county): 409 Camden Ave. Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4-24-1966

23c. NAME OF CEMETERY OR CREMATORY: Downing Methodist

23d. LOCATION (City, town or county) (State): Oak Hall, Virginia

24. FUNERAL DIRECTOR: Robert H. Watson — ADDRESS: Pocomoke City, Md.

25a. REC'D BY REGISTRAR DATE: APR 25 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A1SME (5)
5M 1/65

1 M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06150

CERTIFICATE OF DEATH

06146

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 720 E.Church Street

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury 22-1
d. STREET ADDRESS: 720 E.Church St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First RAYMOND — Middle EDWARD — Last LINES, SR.

4. DATE OF DEATH: Month APRIL — Day 5 — Year 1966

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 26/1890

9. AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months 9 — Days 9
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House painter

10b. KIND OF BUSINESS OR INDUSTRY: Painting

11. BIRTHPLACE (County & State, or foreign country): Pa.

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: (NK)

14. MOTHER'S MAIDEN NAME: (NK)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): Yes (Mexican)

16. SOCIAL SECURITY NO.: 236-28-6444

17. INFORMANT: Mrs. Mary E.Lines(Wife) Address: 216 Tilghman St. Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Embolism — INTERVAL BETWEEN ONSET AND DEATH:

4201
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic Hypertension
DUE TO (c): Heart Disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): N/A

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from _____, 19___, to _____, 19___, that (I) (we) last saw the deceased alive on _____ 19___, and that death occurred at A. M, from the causes and on the date stated above.

22a. SIGNATURE: Carrie Hearn M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: Apr. 8 /1966

22c. PHYSICIAN'S NAME (Type): Dr.Cafrie I.Hearn

22d. ADDRESS: N.Division St. Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Apr.8/1966

23c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery

23d. LOCATION (City, town or county) (State): Salisbury, Maryland

24. FUNERAL DIRECTOR: HOLLOWAY & COMPANY — ADDRESS: SALISBURY, MARYLAND

25a. REC'D BY REGISTRAR DATE: APR 14 1966

25b. REGISTRAR'S SIGNATURE: J.Charles Judge

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06151 — 06147

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH a. COUNTY: Wicomico	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Maryland b. COUNTY: Wicomico
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury — c. LENGTH OF STAY IN 1b: Since 8/10/65	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury 22-1
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Pine Bluff State Hospital	d. STREET ADDRESS: 304 Delaware Avenue — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒
3. NAME OF DECEASED (Type or print): First: Andrew — Middle: - — Last: Lyles	4. DATE OF DEATH: Month: April — Day: 19 — Year: 19 66
5. SEX: Male	6. COLOR OR RACE: Colored
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: Nov. 10, 1910
9. AGE (In years last birthday): 55 yrs.	IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer	10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (County & State, or foreign country): Jasper Co., Miss.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Lord Lyles	14. MOTHER'S MAIDEN NAME: Cemilli McLaurin
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): Unknown	16. SOCIAL SECURITY NO.: 428-24-2347
17. INFORMANT Address: Records of Pine Bluff State Hospital	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchogenic Carcinoma — INTERVAL BETWEEN ONSET AND DEATH: Unknown
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1621
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19 — 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I (this hospital) attended the deceased from Aug. 10, 19 65 to April 19 19 66 that I (we) last saw the deceased alive on April 19 19 66, and that death occurred at 6:40 a M, from causes and on the date stated above.

22a. SIGNATURE: E. P. Ritchings — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 4/19/66

22c. PHYSICIAN'S NAME (Type): E. P. Ritchings — 22d. ADDRESS: Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	4/23/1966	Green Acres	Salisbury Md.

24. FUNERAL DIRECTOR: Clinton F. Stewart — ADDRESS: Salis Md

25a. REC'D BY REGISTRAR: APR 22 1966 — 25b. REGISTRAR'S SIGNATURE: Charles Judge

1

FOR STATE HEALTH DEPT.

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06152

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06148

1. PLACE OF DEATH
   a. COUNTY: Wicomico — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: Delaware
   b. COUNTY:
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Millsboro R.F.D. 46-3
   d. STREET ADDRESS: Greenhaven
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Margie — Middle: M — Last: Lynch

4. DATE OF DEATH: Month: 4-21-66 — Day: — Year: 19

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10/24/1892

9. AGE (In years last birthday): 73 yrs.
   IF UNDER 1 YEAR: Months / Days
   IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: Self

11. BIRTHPLACE (State or foreign country): Del.

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Isaac B. Morris

14. MOTHER'S MAIDEN NAME: Mary E. Brittingham

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Address: Alfred Lynch – Millsboro – Del.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
   DUE TO
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b):
   DUE TO
   (c):
   4201

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer M.D.

EXAMINER'S NAME (Type): Earl L. Royer, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county): 109 Camden Ave. Salisbury, Md.

22. DATE SIGNED: 4-21-66

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/24/66

23c. NAME OF CEMETERY OR CREMATORY: Pine Cemetery

23d. LOCATION (City or Town) (County) (State): Whitesville Del.

24. FUNERAL DIRECTOR / ADDRESS: Ronald Tanner – Millsboro, Del.

25a. FILED BY (REGISTRAR): DATE: APR 27 1966

25b. (REGISTRAR'S SIGNATURE):

VR A15ME (5) 6M 1/66

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06153 — 06149

1. PLACE OF DEATH
a. COUNTY: WICOMICO — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): PENINSULA GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Va. — b. COUNTY: Accomack
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Horntown — 83-3
d. STREET ADDRESS: P.O. Box 3
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: CLARENCE — Middle: — Last: MARSHALL

4. DATE OF DEATH: Month: APRIL — Day: 30 — Year: 1966

5. SEX: MALE

6. COLOR OR RACE: NEGRO

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: Mar. 3, 1884

9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (County & State, or foreign country): Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry Marshall

14. MOTHER'S MAIDEN NAME: Charoletta Logan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 229-38-9375

17. INFORMANT: Madelyn Hosp — Address: Horntown, Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic cardiovascular disease
4221
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Pneumonia
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Benign prostatic hypertrophy.

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) this hospital attended the deceased from 3-9, 1966, to 4-30, 1966, that (I) (we) last saw the deceased alive on 4-30 1966, and that death occurred at 10:45 AM, from the causes and on the date stated above.

22a. SIGNATURE: Francis A. Clark Jr. M.D. — ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [X]

22b. DATE SIGNED: 4-30-66

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS: c/o Peninsula General Hospital

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5-7-66

23c. NAME OF CEMETERY OR CREMATORY: Dee's Chapel Cem.

23d. LOCATION (City, town or county) (State): Horntown, Va.

24. FUNERAL DIRECTOR: Samuel Long — ADDRESS: New Church, Va.

25a. REC'D BY REGISTRAR DATE: MAY 4 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06154

CERTIFICATE OF DEATH

06150

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Wicomico — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Virginia — b. COUNTY: Accomack
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chincoteague 23-3
   d. STREET ADDRESS: 109 Church Street
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle: Richard — Last: McAllen

4. DATE OF DEATH: Month: April — Day: 8 — Year: 1966

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov. 20, 1919

9. AGE (In years last birthday): 46 yrs.
   IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Welder

10b. KIND OF BUSINESS OR INDUSTRY: U. S. A.

11. BIRTHPLACE (County & State, or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Arthur G. McAllen

14. MOTHER'S MAIDEN NAME: Evelyn Savage

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes
    (If yes give war or dates of service): W. W. II

16. SOCIAL SECURITY NO.: 214-08-0835

17. INFORMANT: Irma McAllen — Address: Chincoteague, Virginia

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Heart Failure
416X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Rheumatoid Heart Disease
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 4 mo

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Rheumatoid lung disease, Rheumatoid Arthritis

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from _____, 19___, to _____, 19___, that (I) (we) last saw the deceased alive on _____ 19___, and that death occurred at 11:00 M, from the causes and on the date stated above.

22a. SIGNATURE: Joseph C. Fitzgerald M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9 April 66

22c. PHYSICIAN'S NAME (Type):

22d. ADDRESS: Medical Center

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4-11-1966

23c. NAME OF CEMETERY OR CREMATORY: Beulah Cemetery

23d. LOCATION (City, town or county) (State): Salisbury Md.

24. FUNERAL DIRECTOR — ADDRESS: Salyer Funeral Home, Chincoteague, Virginia

25a. REC'D BY REGISTRAR DATE: APR 13 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06155 06151

1. PLACE OF DEATH
a. COUNTY Wicomico MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
e. STATE MARYLAND b. COUNTY WICOMICO
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fruitland
d. STREET ADDRESS Hayward Ave. 22.1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Omar Middle WASHINGTON Last McAllister
4. DATE OF DEATH Month April Day 14 Year 1966
5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDDWED ☐ DIVORCED ☐
8. DATE OF BIRTH Jan. 6 1897
9. AGE (In years last birthday) 69 Yrs.
IF UNDER 1 YEAR Months 3 Days 8 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired laborer-Machinist-Factory
10b. KIND OF BUSINESS OR INDUSTRY shirt
11. BIRTHPLACE (County & State, or foreign country) Dor. Co. Elliott's Island, Md
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME James McAllister
14. MOTHER'S MAIDEN NAME Mamie

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) Unk (If yes give war or dates of service)
16. SOCIAL SECURITY NO. 214-07-8505
17. INFORMANT Address Mrs. Natalie M. McAllister (Wife) Hayward Ave. Salisbury, Md. PI-2-5592

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] #21801
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema - INTERVAL BETWEEN ONSET AND DEATH
4200
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Arteriosclerotic heart disease
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

2Da. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) N/A
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4-9, 1966, to 4-14, 1966, that (I) (we) last saw the deceased alive on 4-14-1966, and that death occurred at 6:15 M, from the causes and on the date stated above.

22a. SIGNATURE James L. Clifford M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED Apr. 15/1966
22c. PHYSICIAN'S NAME (Type) Dr. James L. Clifford
22d. ADDRESS Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF April 17/66
23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park
23d. LOCATION (City, town or county) (State) Salisbury, Maryland

24. FUNERAL DIRECTOR HOLLOWAY & COMPANY
ADDRESS SALISBURY, MARYLAND
25a. REC'D BY REGISTRAR DATE APR 20 1966
25b. REGISTRAR'S SIGNATURE J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06156 — 06152

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury, Md.
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 709 Ferndale Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: William — Middle: Adams — Last: McCarty

4. DATE OF DEATH: Month: April — Day: 29 — Year: 1966

5. SEX: Male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 10/1904

9. AGE (In years last birthday): 61 yrs. — IF UNDER 1 YEAR: Months: 10 Days: 19 — IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Manager-Optical Co.

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Phila. Pa.

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Frank McCarty

14. MOTHER'S MAIDEN NAME: Thekla Findeson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Norma McCarty (Wife) Address: 709 Ferndale Road Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pulmonary Embolus — INTERVAL BETWEEN ONSET AND DEATH: Min.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 163X
DUE TO (b): Carcinoma of left lung c Metastasis of brain — months
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from April 28, 1966 to April 29, 1966, that (I) (we) last saw the deceased alive on April 29 1966, and that death occurred at 4:35 P.M., from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.O. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 4/29/66

22c. PHYSICIAN'S NAME (Type): Dr. Gutierrez

22d. ADDRESS: Deer's Head State Hospital

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: May 4/1966

23c. NAME OF CEMETERY OR CREMATORY: Arlington Memorial Park

23d. LOCATION (City, town or county) (State): Allentown, Pa.

24. FUNERAL DIRECTOR: HOLLOWAY & COMPANY

ADDRESS: SALISBURY, MARYLAND

25a. REC'D BY REGISTRAR DATE: MAY 5 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06157 — 06153

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
e. COUNTY: Wicomico
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 12 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Tyaskin
d. STREET ADDRESS: 22-1
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Herbert Middle: Luther Last: Mezick
4. DATE OF DEATH: Month: April Day: 9 Year: 1966

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 3/19/1900
9. AGE (In years last birthday): 66 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Luther Messick
14. MOTHER'S MAIDEN NAME: Carrie Robertson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 218-03-0104
17. INFORMANT: Mr. Noble Messick Elgin Illinois — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarctions (x2) — INTERVAL BETWEEN ONSET AND DEATH: 12 days
4201
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
DUE TO (b): Coronary Arteriosclerosis. — Years.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 3/28/66 to 4/9/66, that (I) (we) last saw the deceased alive on 4/9/66, and that death occurred at 1:58 M, from the causes and on the date stated above.

22a. SIGNATURE: O. J. Burton M.D. ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED: 4/10/66
22c. PHYSICIAN'S NAME (Type): O. J. Burton
22d. ADDRESS: Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 4/13/66
23c. NAME OF CEMETERY OR CREMATORY: Tyaskin Cem.
23d. LOCATION (City, town or county) (State): Tyaskin Md.

24. FUNERAL DIRECTOR: C. D. Masid ADDRESS: Bivalve, Md.
25a. REC'D BY REGISTRAR DATE: APR 14 1966
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06158 — 116154

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Pen.Gen.Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 401 Elizabeth Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First STANLEY — Middle CHARLES — Last MILES

4. DATE OF DEATH: Month APRIL — Day 30th — Year 19 66

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Apr.20/1907

9. AGE (In years last birthday): 59 yrs. — IF UNDER 1 YEAR: Months 0 Days 10 — IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Railroad employee-

10b. KIND OF BUSINESS OR INDUSTRY: Cook

11. BIRTHPLACE (County & State, or foreign country): Fairmount(Som.Co.)Md.

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Howard Miles

14. MOTHER'S MAIDEN NAME: Josephine Howeth

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 214-10-7896

17. INFORMANT: Mrs. Iva M. Miles (Wife) Address: 401 Elizabeth St Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Embolism — INTERVAL BETWEEN ONSET AND DEATH:

Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
DUE TO (b): Thrombophlebitis Saphenous vein — 2 weeks
DUE TO (c):

464 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): N/A

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 29 Apr. 19 66, to 30 Apr., 1966, that (I) (we) last saw the deceased alive on 30 Apr. 19 66, and that death occurred at App-8:20P. M, from the causes and on the date stated above.

22a. SIGNATURE: Joseph C. Fitzgerald — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: May 4 /1966

22c. PHYSICIAN'S NAME (Type): Dr. Joseph Fitzgerald, Dr. James L. Clifford — 22d. ADDRESS: Medical Center Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: May 4/1966 — 23c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery — 23d. LOCATION (City, town or county) (State): Salisbury, Maryland

24. FUNERAL DIRECTOR: HOLLOWAY & COMPANY — ADDRESS: SALISBURY, MARYLAND — 25a. RECD BY REGISTRAR DATE: MAY 9 1966 — 25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06159 — 06155

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: WORCESTER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WHALEYSVILLE 28-2
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: JOSHUA — Middle: J. — Last: Morris
4. DATE OF DEATH: Month: April — Day: 13 — Year: 1966

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Oct. 8, 1902
9. AGE (In years last birthday): 63 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER POULTRYMAN
10b. KIND OF BUSINESS OR INDUSTRY: FARM
11. BIRTHPLACE (County & State, or foreign country): BISHOP MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOSHUA A. MORRIS
14. MOTHER'S MAIDEN NAME: ANNA HICKMAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: 213-05-0740
17. INFORMANT: MRS LORETTA NISBET — Address: SALISBURY MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: Hours.
4211
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic aortic Stenosis
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Generalized arteriosclerosis
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Not, 1962 to 4/13, 1966, that (I) (we) last saw the deceased alive on 4/13 1966, and that death occurred at 9:00 M, from the causes and on the date stated above.

22a. SIGNATURE: Paul M Beardsley — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 4/14/66.
22c. PHYSICIAN'S NAME (Type):
22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 4/17/66
23c. NAME OF CEMETERY OR CREMATORY: SUNSET MEMORIAL PARK
23d. LOCATION (City, town or county) (State): BERLIN MD

24. FUNERAL DIRECTOR: Anna A. Burbage — ADDRESS: Berlin md
25a. REC'D BY REGISTRAR DATE: APR 18 1966
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
15M 4-64

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06160

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06156

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Eden (Rural)
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Corner- Camden Ave.Ext. and S.Div. Street Ext.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
e. STATE: Maryland b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Eden (Rural) 22-1
d. STREET ADDRESS: R.D.# 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First WILLARD Middle MAYHEW Last MORRIS

4. DATE OF DEATH: Month APRIL Day 29 Year 1966

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb.8/1914

9. AGE (In years last birthday): 52 yrs. IF UNDER 1 YEAR: Months 2 Days 21 IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lineman-Construction

10b. KIND OF BUSINESS OR INDUSTRY: Co.

11. BIRTHPLACE (State or foreign country): Allen, Maryland

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Marion F.Morris

14. MOTHER'S MAIDEN NAME: Laura Brumley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): Yes W.W.#II A.F.

16. SOCIAL SECURITY NO.: 220-10-8083

17. INFORMANT: Mrs.Harriet W.Morris(Wife) Address: R.D.#2 Eden,Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Fracture dislocation lower cervical spine — INTERVAL BETWEEN ONSET AND DEATH: Sudden

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): Driver of car involved in a two car collision.

20c. TIME OF INJURY Month, Day, Year: Apr. Hour 7:00 a.m. 4/29 1966

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Highway

20f. (City or town) (County) (State): Fruitland Wicomico- Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Roye M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): Dr.Earl L.Roye

Address (Street, city, town, or county): 409 Camden Ave. Salisbury, Md.

DATE SIGNED: May 3 /1966

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: May 2/1966

23c. NAME OF CEMETERY OR CREMATORY: Allen Cemetery

23d. LOCATION (City, town or county) (State): Allen, Maryland

24. FUNERAL DIRECTOR: HOLLOWAY & COMPANY ADDRESS: SALISBURY, MARYLAND

25a. REC'D BY REGISTRAR DATE: MAY 5 1966

25b. REGISTRAR'S SIGNATURE: J Charles Judge

VR A1SME (5) 5M 1/65

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06161

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06157

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Wicomico
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
   c. LENGTH OF STAY IN 1b: MARYLAND
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Wicomico
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
   d. STREET ADDRESS: Route 3
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARGARET Middle D. Last MURPHY

4. DATE OF DEATH: Month 4-13-66 Day Year 19

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 4-13-84

9. AGE (In years last birthday): 82 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Domestic

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Thomas Pilkerton

14. MOTHER'S MAIDEN NAME: Mary Tippett

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: Louis Murphy, Waldorf, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary embolus — INTERVAL BETWEEN ONSET AND DEATH: Sudden

Conditions, if any, which gave rise to immediate cause (a), steting the underlying cause last.
DUE TO (b): Fracture of left hip — 3 wks.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): Fell at home.

20c. TIME OF INJURY Month, Dey, Year: Hour p.m. 3-21-66

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Own home

20f. (City or town) (County) (State): Salisbury Wicomico Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): Earl L. Royer, M.D.

Address (Street, city, town, or county): 409 Camden Ave., Salisbury, Md.

22. DATE SIGNED: 4-14-66

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4-16-66

23c. NAME OF CEMETERY OR CREMATORY: St Marys Cemetery

23d. LOCATION (City, town or county) (State): Bryantown, Maryland

24. FUNERAL DIRECTOR ADDRESS: The Huntt Funeral Home, Waldorf, Md.

25a. REC'D BY REGISTRAR DATE: APR 18 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR AISME (5) 5M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06162 06158

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: Adm. in ED 4/21/66
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Pen.Gen.Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury - Rural
d. STREET ADDRESS: R.D.#3 Mt. Vernon Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First DAISEY Middle NOCK Last PIERCE
4. DATE OF DEATH: Month APRIL Day 25 Year 1966
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Nov. 7/1923
9. AGE (In years last birthday): 42 yrs. IF UNDER 1 YEAR: Months 5 Days 18 IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (County & State, or foreign country): Stockton(Wor.Co.)Md.
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: David Watson Hancock
14. MOTHER'S MAIDEN NAME: Daisey Nock Ward
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 218-12-1347
17. INFORMANT: Mr. Burl Pierce(Husband) Address: Mt. Vernon Ave R.D.#3 Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Status Asthmaticus — INTERVAL BETWEEN ONSET AND DEATH: 4 days
241X
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. DUE TO (b): DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4/21, 1966 to 4/25, 1966, that (I) (we) last saw the deceased alive on 4/25 1966, and that death occurred at Apr. 2:30 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Wilbur D. Gray M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Apr. 28 /1966
22c. PHYSICIAN'S NAME (Type): Dr. William D. Gray
22d. ADDRESS: Camden Ave. Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Apr. 28/1966
23c. NAME OF CEMETERY OR CREMATORY: Portersville Church Cem.(Worcester Co., Md.)
23d. LOCATION (City, town or county) (State)

24. FUNERAL DIRECTOR: HOLLOWAY & COMPANY ADDRESS: SALISBURY, MARYLAND
25a. REC'D BY REGISTRAR DATE: MAY 2 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20M 1/65

X

1

FOR STATE HEALTH DEPT.

M

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06163

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06159

1. PLACE OF DEATH
a. COUNTY: Wicomico
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ocean City
d. STREET ADDRESS: Route 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First CARL Middle P. Last PRUITT

4. DATE OF DEATH: Month 4-14-66 Day Year 19

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 8-23-1882

9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Custodian

10b. KIND OF BUSINESS OR INDUSTRY: School

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Marcel Pruitt

14. MOTHER'S MAIDEN NAME: Millie Blades

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): ----

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT Address: Mrs. Nellie P. Kelly, Ocean City, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchial pneumonia
DUE TO (b): Diabetes Mellitus
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), steting the underlying cause last.

260X

INTERVAL BETWEEN ONSET AND DEATH: Days / Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Fracture of left hip, intertrochanteric

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): Fell at home.

20c. TIME OF INJURY Month, Dey, Yeer Hour e.m.: 4-1-66

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Own home.

20f. (City or town) (County) (State): Ocean City, Worcester, Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L Royer M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22. DATE SIGNED: 4-16-66

EXAMINER'S NAME (Type): Earl L. Royer, M.D.

Address (Street, city, town, or county): 409 Camden Ave., Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/16/66

23c. NAME OF CEMETERY OR CREMATORY: Springhill Cemetery

23d. LOCATION (City, town or county) (State): Girdletree, Md.

24. FUNERAL DIRECTOR: Thomas E. Thomas

ADDRESS: Snow Hill, Maryland

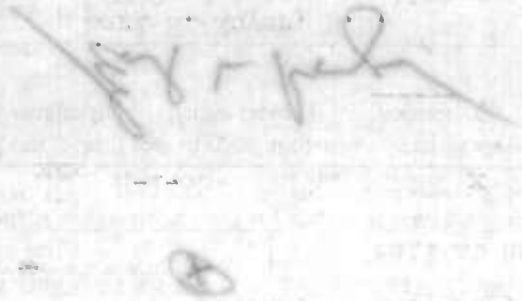
25c. REC'D BY REGISTRAR DATE: APR 20 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1SME (5)
5M 1/65



Item 18 Film G376 4/22/66 mh

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06164

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06160

Item 9 Film G375 4/21/66 mh

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bishop
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Anna — Middle: Stella — Last: Purnell

4. DATE OF DEATH: Month: 4-14-66 — Day — Year: 19

5. SEX: F

6. COLOR OR RACE: AA

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2-18-24

9. AGE (In years last birthday): 32/42 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Day Laborer

10b. KIND OF BUSINESS OR INDUSTRY: field hand

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Harold Purnell

14. MOTHER'S MAIDEN NAME: Ella H. Showell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 218-24-4071

17. INFORMANT: Ella Purnell — Address: Bishop, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), end (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute tracheal bronchitis — INTERVAL BETWEEN ONSET AND DEATH: Week
500X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒ Inquiry ☒, and in my opinion death resulted from Natural causes ☒ Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22. DATE SIGNED: 4-18-66

EXAMINER'S NAME (Type): Earl L. Royer, M.D.

Address (Street, city, town, or county): 409 Camden Ave. Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Apr. 17, 1966
23c. NAME OF CEMETERY OR CREMATORY: Showell Cem.
23d. LOCATION (City, town or county) (State): Showell Md.

24. FUNERAL DIRECTOR: Douglas Milson — ADDRESS: Frankford, Md.

25a. REC'D BY REGISTRAR: APR 21 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
5M 1/65

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06165

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06161

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hebron
c. LENGTH OF STAY IN 1b: minutes
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Ghost Light Road

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pocomoke City
d. STREET ADDRESS: RFD 3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First KENNETH — Middle LEE — Last PUSEY

4. DATE OF DEATH: Month 4 — Day 23 — Year 19 66

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 22, 1943

9. AGE (In years last birthday): 23 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck Driver

10b. KIND OF BUSINESS OR INDUSTRY: Office Supply Delivery

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Walter Thompson Pusey

14. MOTHER'S MAIDEN NAME: Eloise Ardis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): --

16. SOCIAL SECURITY NO.: unk.

17. INFORMANT — Address: Mrs Eloise A. Pusey, Pocomoke, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Total burns — INTERVAL BETWEEN ONSET AND DEATH: Minutes
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Occupant in parked vehicle struck by another vehicle.

20c. TIME OF INJURY Month, Day, Year Hour a.m.: 1:30 ~~XX~~ 4-23-66

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.): Ghost Light Road

20f. (City or town) (County) (State): Hebron, Wicomico, Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer M.D.

EXAMINER'S NAME (Type): Earl L. Royer, M.D.

Address (Street, city, town, or county): 409 Camden Ave., Salisbury, Md.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22. DATE SIGNED: April 25, 1966

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4-26-1966

23c. NAME OF CEMETERY: First Baptist

23d. LOCATION (City or Town) (County) (State): Pocomoke Worcester, Md

24. FUNERAL DIRECTOR: Robert H. Watson — ADDRESS: Pocomoke City, Md.

25a. REC'D BY REGISTRAR — DATE: APR 29 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06166 06162

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Wicomico
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
   c. LENGTH OF STAY IN 1b
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General 80

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: MARYLAND
   b. COUNTY: SOMERSET ✓
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): MARION STATION 19-2
   d. STREET ADDRESS
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William Middle: Calvin Last: Pusey

4. DATE OF DEATH: Month: April Day: 14 Year: 1966

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: NOV. 21, 1883

9. AGE (In years last birthday): 82 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MACHINIST

10b. KIND OF BUSINESS OR INDUSTRY: MARINE ENGINES

11. BIRTHPLACE (County & State, or foreign country): MARION STATION, MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILLIAM PUSEY

14. MOTHER'S MAIDEN NAME: BERTHA COULBOURN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 466-07-5199

17. INFORMANT: Address: MRS. EDNA ANDREW - 305 GORDY RD. - SALISBURY, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 2 wks

410 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Mitral Stenosis & Insufficiency — Unk.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20

2Da. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

2Dc. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

2Dd. INJURY OCCURRED While at work ☐ Not While at work ☐

2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

2Df. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4-11, 1966, to 4-14, 1966, that (I) (we) last saw the deceased alive on 4-13 1966, and that death occurred at 3:10 A M, from the causes and on the date stated above.

22a. SIGNATURE: George H. Henning — M.O. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4-14-66

22c. PHYSICIAN'S NAME (Type): GEORGE H. HENNING

22d. ADDRESS: Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 4/16/66

23c. NAME OF CEMETERY OR CREMATORY: ST. PAUL'S CEMETERY

23d. LOCATION (City, town or county) (State): MARION STATION, MD.

24. FUNERAL DIRECTOR: BRADSHAW & SONS

ADDRESS: CRISFIELD, MD.

25a. RECD BY REGISTRAR DATE: APR 18 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
15M 4-64

BP

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06167 06163

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 412 Camden Court

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 412 Camden Court
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
HOWARD	THOMAS	RICHARDSON	APRIL	25	1966

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	7. ☒ MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED	July 3/1897	68 yrs.	9	22		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Salesman - Tobacco		Wor.Co.Maryland	U S A

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
James Thomas Richardson	Margaret Matilda Bonneville

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
Yes W.W.#I	086-01-5263	Mrs.Mary S.Richardson(Wife)412 Camden Court Salisbury,Md. 21801

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Multiple Myeloma	9 months
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b)	203 X	
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
	N/A

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	2Df. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 11-21 19 60, to 4-25 19 66, that (I) (we) last saw the deceased alive on 4-18 19 66, and that death occurred at Apr 6:00A M, from the causes and on the date stated above.

22a. SIGNATURE	M.D.	ATTENDING PHYS. ☒	MED. DIRECTOR ☐	STAFF PHYS. ☐	22b. DATE SIGNED
Earl L. Boyer					Apr. 25 /1966

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
Dr.Earl L.Boyer	409 Camden Ave.Salisbury,Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
Burial	Apr.28/1966	Wicomico Memorial Park	Salisbury,Maryland

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
HOLLOWAY & COMPANY	SALISBURY,MARYLAND	APR 26 1966	J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

M 06168 06164

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Wicomico — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Worcester
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Berlin
   d. STREET ADDRESS: RFD #3, Box 219
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: A. — Last: Robbins

4. DATE OF DEATH: Month: April — Day: 10, — Year: 1966

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Sept. 1, 1891

9. AGE (In years last birthday): 74 yrs. — IF UNDER 1 YEAR: Months: 7 — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Worcester, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Smack

14. MOTHER'S MAIDEN NAME: Annie Perdue

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Arnold Robbins, RFD # Box 2A, Berlin, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Acute Pulmonary Edema	1 hour
DUE TO (b)	Congestive Heart Failure	1 week
DUE TO (c)		

4341

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8/12/57, 19—, to 4/10/66, 19—, that (I) (we) last saw the deceased alive on 4/10/66 19—, and that death occurred at 10 A M, from the causes and on the date stated above.

22a. SIGNATURE: Ivory U. Sully, Jr. M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4/13/66

22c. PHYSICIAN'S NAME (Type): Ivory U. Sully, Jr., MD

22d. ADDRESS: P. O. Box 126, Berlin, Md. 21811

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 4-14-66 — 23c. NAME OF CEMETERY OR CREMATORY: New Bethel — 23d. LOCATION (City, town or county) (State): Berlin, Md.

24. FUNERAL DIRECTOR — ADDRESS: Loretta B. Jolley — Jersey Rd. Salisbury

25a. REC'D BY REGISTRAR DATE: APR 20 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4) 20M 1/65

1

FOR STATE HEALTH DEPT.

M

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06169

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06165

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Pen.Gen.Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Quantico - Rural
d. STREET ADDRESS: P.O.B.#84
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First RUSSELL — Middle ALBERT — Last ROBERTS
4. DATE OF DEATH: Month APRIL — Day 19 — Year 1966

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White	MARRIED [X]	March 13/1886	80 yrs.	1	6		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Clara(Wico.Co.)Md.
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Benjamin O.Roberts
14. MOTHER'S MAIDEN NAME: Zipporah Price

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs.Emma C.Roberts(Wife) Address: Box#84 Quantico, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Rupture of gall bladder	Hours
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b)	Lacerated liver	Hours
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. EXTERNAL CAUSE WAS PRIMARY [X] or CONTRIBUTING [ ] CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): Car ran off road.
20c. TIME OF INJURY Hour e.m. 3 — Month, Day, Year 4-18-66
20d. INJURY OCCURRED While at work [ ] Not While at work [X]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): L. Dashiell Road
20f. (City or town) (County) (State): Salisbury, Wicomico, Md.

21. I certify that I took charge of the remains described above, held an Autopsy [X], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Earl L. Royer M.D.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
22. DATE SIGNED: April 22 /1966

EXAMINER'S NAME (Type): Dr.Earl L.Royer
Address (Street, city, town, or county): 409 Camden Ave.Salisbury,Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Apr.22/1966
23c. NAME OF CEMETERY OR CREMATORY: Wicomico Memorial Park
23d. LOCATION (City, town or county) (State): Salisbury, Maryland

24. FUNERAL DIRECTOR: HOLLOWAY & COMPANY
ADDRESS: SALISBURY, MARYLAND
25a. REC'D BY REGISTRAR DATE: APR 25 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
5M 1/65

Items 18&21 Film G376

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06170 06166

1. PLACE OF DEATH
a. COUNTY: Wicomico
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Pen.Gen.Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 103 Shad Point Road
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First HERBERT Middle EUGENE Last ROSS
4. DATE OF DEATH: Month APRIL Day 16 Year 1966
5. SEX: Male
6. COLOR OR RACE: white
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [X]
8. DATE OF BIRTH: Sept.23/1893
9. AGE (In years last birthday): 72 yrs. IF UNDER 1 YEAR: Months 6 Days 23 IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Policeman
10b. KIND OF BUSINESS OR INDUSTRY: Police
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: Conrad Ross
14. MOTHER'S MAIDEN NAME: (Unk)
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 063-22-4148
17. INFORMANT Address: Mr.Eugene A.Ross(Son)184 Harrison St New Milford,N.J.Phone-201-261-8986

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute adrenal insufficiency with hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Chronic pancreatitis — days
DUE TO (c): Chronic alcoholism — years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy [X], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Earl L Royer M.D.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
22. DATE SIGNED
EXAMINER'S NAME (Type): Dr.Earl L.Royer
Address (Street, city, town, or county): 409 Camden Ave.Salisbury,Md.
April 18 /1966

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: April 18/66
23c. NAME OF CEMETERY OR CREMATORY: Wicomico Memorial Park
23d. LOCATION (City, town or county) (State): Salisbury, Maryland

24. FUNERAL DIRECTOR: HOLLOWAY & COMPANY
ADDRESS: SALISBURY, MARYLAND
25a. REC'D BY REGISTRAR DATE: APR 20 1966
25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 5M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06171 06167

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Wicomico
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
   c. LENGTH OF STAY IN 1b: MARYLAND
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Worcester
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Snow Hill
   d. STREET ADDRESS: 100 E. Federal Street
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Cornelia Middle D. Last Shockley

4. DATE OF DEATH: Month April Day 25 Year 1966

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: August 3 1880

9. AGE (In years last birthday): 85 yrs.
   IF UNDER 1 YEAR: Months ___ Days ___
   IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): Snow Hill, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert H. Davis

14. MOTHER'S MAIDEN NAME: Cornelia Dixon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
    (If yes give war or dates of service): —

16. SOCIAL SECURITY NO.: 220 44 2536

17. INFORMANT: Mrs. Ethel S. Gladding, Address: Snow Hill, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
    PART I. DEATH WAS CAUSED BY:
    IMMEDIATE CAUSE (a): Bronchiolitis – Viral
    480X
    DUE TO (b): Influenza
    Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.
    DUE TO (c):
    INTERVAL BETWEEN ONSET AND DEATH: 3 days.

    PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Left Ventricular Failure DS HD

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Ap. 24, 1966, to Ap 25, 1966, that (I) (we) last saw the deceased alive on Ap 25 1966, and that death occurred at ___M, from the causes and on the date stated above.

22a. SIGNATURE: David Rafat M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4-25-66

22c. PHYSICIAN'S NAME (Type): DAVID RAFAT

22d. ADDRESS: SNOW HILL MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/29/66

23c. NAME OF CEMETERY OR CREMATORY: Bates Meth. Cemetery

23d. LOCATION (City, town or county) (State): Snow Hill Maryland

24. FUNERAL DIRECTOR: Lemmon F. Lemmon ADDRESS: Snow Hill, Md.

25a. REC'D BY REGISTRAR DATE: APR 28 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
15M 4-64

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06172

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06168

1. PLACE OF DEATH
   a. COUNTY: Wicomico — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury(
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D.O.A.Pen.Gen.Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Wicomico
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury (Forest Lake) 22-1
   d. STREET ADDRESS: 1913 Kipling Dr.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM — Middle VINCENT — Last SHOCKLEY

4. DATE OF DEATH: Month April — Day 20 — Year 1966

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov. 24/1927

9. AGE (In years last birthday): 38 yrs. — IF UNDER 1 YEAR: Months 4, Days 26 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Co-owner Carpet Co.

10b. KIND OF BUSINESS OR INDUSTRY: Carpet

11. BIRTHPLACE (State or foreign country): Willards, Maryland

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: William Franklin Shockley

14. MOTHER'S MAIDEN NAME: Lida L.Shockley Shockley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs.Elizabeth Catherine Shockley(Wife) — Address: 1913 Kipling Dr.(Forest Lake)Salisbury Maryland.21801 (PI-2-1222)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Fx Cervical Spine — INTERVAL BETWEEN ONSET AND DEATH: Sudden

8250

Conditions, if any, which gave risa to immediate causa (a), stating the underlying cause last. DUE TO (b): — DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): Truck accident.

20c. TIME OF INJURY Hour ___ a.m. p.m. Month, Day, Year: 4/20 1966

20d. INJURY OCCURRED While at work ☒ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Highway

20f. (City or town) Westover ✓ (County) Somerset- (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22. DATE SIGNED: April 21 /1966

EXAMINER'S NAME (Type): Dr.Earl L.Royer

Address (Street, city, town, or county): 409 Camden Ave.Salisbury,Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Apr.23/1966

23c. NAME OF CEMETERY OR CREMATORY: Line Church Cemetery

23d. LOCATION (City, town or county) (State): Wicomico Co.Maryland

24. FUNERAL DIRECTOR: HOLLOWAY & COMPANY — ADDRESS: SALISBURY, MARYLAND

25a. REC'D BY REGISTRAR DATE: APR 25 1966

25b. REGISTRAR'S SIGNATURE: J.Charles Judge

VR AISME (5) 5M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06173 Item 8 Film 6376 5/5/66 mh 06169

1. PLACE OF DEATH
e. COUNTY Wicomico
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
e. STATE Maryland b. COUNTY Somerset
c. CITY OR TOWN (If outside corporate limits, write RURAL end give nearest town) Princess Anne
d. STREET ADDRESS Antioch Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Grace Middle: E. Last: Siddons
4. DATE OF DEATH Month: April Day: 28 Year: 1966
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH April 28, 2/4/1886
9. AGE (In years last birthday) 80 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (County & State, or foreign country) Springville, New York
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Fred Siddons
14. MOTHER'S MAIDEN NAME Kate Hawley
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address: Mrs. Ethel Siddons, Princess Anne, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure
4500
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (b) Generalized Arteriosclerosis
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from April 6, 19 66 to April 29 19 66, that (I) (we) last saw the deceased alive on April 29 19 66, and that death occurred at 7:25 P.M. from the causes and on the date stated above.

22a. SIGNATURE John F. Butler Jr. M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED April 29
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF Entombed 4/30/1966
23c. NAME OF CEMETERY OR CREMATORY Emanuel Cemetery
23d. LOCATION (City, town or county) (State) Rural, Princess Anne, Md.

24. FUNERAL DIRECTOR Ernest Harmon ADDRESS Princess Anne, Md.
25a. REC'D BY REGISTRAR DATE MAY 2 1966
25b. REGISTRAR'S SIGNATURE J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06174 06170

1. PLACE OF DEATH
a. COUNTY Wicomico MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Mardela
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Maple Shade Nursing Home

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE Maryland b. COUNTY Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury Rural
d. STREET ADDRESS Allen Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First ELIZABETH Middle ELLA (DISHAROON) Last SMITH
4. DATE OF DEATH Month April Day 16th Year 1966
5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH April 27/1880
9. AGE (In years last birthday) 85 yrs. IF UNDER 1 YEAR Months 11 Days 19 IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife
10b. KIND OF BUSINESS OR INDUSTRY None
11. BIRTHPLACE (County & State, or foreign country) Siloam-Wicomico Co.Md.
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME Jones Bounds
14. MOTHER'S MAIDEN NAME Ann Maria White
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address Mrs. Ethel S. Owens (Step-Daughter) 147 Lakewood Dr. Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 2 hr
331X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) General Arteriosclerosis — 5 years
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

2Da. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan Apr 1966, to April 16, 1966, that (I) (we) last saw the deceased alive on April 15 1966, and that death occurred at 7 P.M., from the causes and on the date stated above.

22a. SIGNATURE H.S. Kuhlman
M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED Apr. 20 /1966
22c. PHYSICIAN'S NAME (Type) H.S.Kuhlman
22d. ADDRESS Sharptown, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF Apr.19/1966
23c. NAME OF CEMETERY OR CREMATORY Allen Cemetery
23d. LOCATION (City, town or county) (State) Allen, Maryland

24. FUNERAL DIRECTOR ADDRESS HOLLOWAY & CO. SALISBURY, MARYLAND
25a. REC'D BY REGISTRAR DATE APR 25 1966
25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06175 06171

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Parsonsburg
d. STREET ADDRESS: XXXXX Shavox
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Evelyn — Middle INA — Last Smith
4. DATE OF DEATH: Month April — Day 19 — Year 1966
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept. 2/1902
9. AGE (In years last birthday): 63 yrs. — IF UNDER 1 YEAR: Months 7 Days 17 Hours Min. — IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (County & State, or foreign country): Mich.
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: John E. Baker
14. MOTHER'S MAIDEN NAME: Lulu Larr
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 213-16-7027
17. INFORMANT: Mr. Preston T. Smith (Husband) — Address: R.D.# (Shavox) Parsonsburg, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): INTRACEREBRAL Hemorrhage, Left — 331X — INTERVAL BETWEEN ONSET AND DEATH: 4 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b): DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): N/A
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4-15, 1966, to 4-19, 1966, that (I) (we) last saw the deceased alive on 4-18 1966, and that death occurred at 5:50 A M, from the causes and on the date stated above.

22a. SIGNATURE: Robt Adkins — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 4/19/66
22c. PHYSICIAN'S NAME (Type): Dr. Robert T. Adkins
22d. ADDRESS: Fruitland, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Apr. 21/1966
23c. NAME OF CEMETERY OR CREMATORY: Wicomico Memorial Park
23d. LOCATION (City, town or county) (State): Salisbury, Maryland

24. FUNERAL DIRECTOR: HOLLOWAY & COMPANY — ADDRESS: SALISBURY, MARYLAND
25a. REC'D BY REGISTRAR DATE: APR 25 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
15M 4-64

1

M 06176

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06172

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH**
   a. COUNTY: Wicomico — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
   c. LENGTH OF STAY IN 1b: 40 Yrs.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 204 Walnut St.,

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Wicomico
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
   d. STREET ADDRESS: 204 Walnut St.,
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First NELLIE — Middle PROUSE — Last SMITH

4. **DATE OF DEATH**: Month 4 — Day 11 — Year 19 66

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8-9-1877

9. AGE (In years last birthday): 88 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Nurse Practical

10b. KIND OF BUSINESS OR INDUSTRY: Nurse

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Richard B. Smith

14. MOTHER'S MAIDEN NAME: Marian Littleton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): ———

16. SOCIAL SECURITY NO.: None

17. **INFORMANT** Address: Mrs. Katherine Taylar Salisbury, Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Congestive Heart Failure	5 Days
DUE TO (b)	Broncho-Pneumonia	2 weeks
DUE TO (c)	Cerebral Embolism	3 weeks

332 1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from ..... 19 67 to April 11, 19 66, that (I) (~~we~~) last saw the deceased alive on April 11 19 66, and that death occurred at 10:20 PM from the causes and on the date stated above.

22a. SIGNATURE: A. C. Newman M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4-14-1966

22c. PHYSICIAN'S NAME (Type): Dr. A.C. Newman

22d. ADDRESS: Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4-14-1966

23c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery

23d. LOCATION (City, town or county) (State): Salisbury, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Hill Funeral Home Salisbury, Maryland

25a. RECD BY REGISTRAR DATE: APR 15 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

Norman T. Baker

VR A15 (4) 20M 5-63 BP

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06177 06173

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest town): Parsonsburg
c. LENGTH OF STAY IN 1b: 5 Mons. ~~22 Yrs.~~
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Shav-ox Rd. Rt #2

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Parsonsburg
d. STREET ADDRESS: Shav-Ox Rd. Rt #2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LAURA — Middle BEALE — Last SPENCER

4. DATE OF DEATH: Month 4 — Day 24 — Year 19 66

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug.5.1884

9. AGE (In years last birthday) yrs.: 81

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): Delaware

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Beale

14. MOTHER'S MAIDEN NAME: UNknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): ----

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT — Address: Mr. W. Oakley Spencer, Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic heart dis. — INTERVAL BETWEEN ONSET AND DEATH: years
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying couse last.
(b)
DUE TO
(c)
4200

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): infected leg ulcers

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from March, 19 66, to April 24, 1966, that (I) (we) last saw the deceased alive on April 24 19 66, and that death occurred at ____ M. from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Dr. L.V. Sohler

22d. ADDRESS: Delmar, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4-27-1966

23c. NAME OF CEMETERY OR CREMATORY: Line Cemetery

23d. LOCATION (City or Town) (County) (State): Whitevilles, Delaware

24. FUNERAL DIRECTOR — ADDRESS: Hill Funeral Home Salisbury, Maryland

25a. REC'D BY REGISTRAR DATE: APR 26 1966

25b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06178 (M) 06174

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 20 years
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Somerset
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Princess Anne
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: — Last: Teagle

4. DATE OF DEATH: Month: April — Day: 19 — Year: 1966

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 11/3/91

9. AGE (In years last birthday): 74 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (County & State, or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: ??

14. MOTHER'S MAIDEN NAME: ??

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: R P. Jones, Princess Anne, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one ceuse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): metastatic Carcinoma Rt Breast — INTERVAL BETWEEN ONSET AND DEATH: 3 years
170X
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
DUE TO (b): chronic nephritis - Uremia
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 3-17, 1966 to 4-19, 1966, that (I) (we) last saw the deceased alive on 4-19-66 19, and that death occurred at 7:30 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Nabil F Warsal. M.O. ☐ ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 4-21-66.

22c. PHYSICIAN'S NAME (Type): NABIL F. WARSAL

22d. ADDRESS: Peninsula Gen. Hosp.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/23/66

23c. NAME OF CEMETERY OR CREMATORY: Esrel Menreal

23d. LOCATION (City, town or county) (Stete): Princess Anne, Md

24. FUNERAL DIRECTOR — ADDRESS: William H. James Jr. Princess Anne, Md

25a. REC'D BY REGISTRAR — DATE: APR 28 1966

25b. REGISTRAR'S SIGNATURE: J Charles Judge

VR A15 (4)
15M 4-64

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06179

CERTIFICATE OF DEATH

06175

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Wicomico — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
   c. LENGTH OF STAY IN 1b: 40 Days
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Deer's Head State Hospital, Salisbury, Md.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Worcester
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Berlin
   d. STREET ADDRESS: Rt. #2, Box 255
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

23.2

3. NAME OF DECEASED (Type or print): First: Jennie; Middle: Lee; Last: Timmons

4. DATE OF DEATH: Month: April; Day: 18; Year: 1966

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: August 12, 1886

9. AGE (In years last birthday): 79 yrs.
   IF UNDER 1 YEAR: Months; Days
   IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): Worcester, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Philmore Dennis

14. MOTHER'S MAIDEN NAME: Sally Anne Huntington

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
    (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Mildred Baker — Address: Snow Hill, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Adenocarcinoma of the uterus — INTERVAL BETWEEN ONSET AND DEATH: 4 years

174 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year; Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 3/9, 1966 to 4/18, 1966, that (I) (we) last saw the deceased alive on 4/18 1966, and that death occurred at 10:20 A.M. from the causes and on the date stated above.

22a. SIGNATURE: L. V. Maldve M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 4/18/66

22c. PHYSICIAN'S NAME (Type): L. V. Maldve, M. D.

22d. ADDRESS: Deer's Head State Hospital, Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: April 22, 1966

23c. NAME OF CEMETERY OR CREMATORY: Evergreen Cem.

23d. LOCATION (City, town or county) (State): Berlin Maryland

24. FUNERAL DIRECTOR: Annie A. Bunbage — ADDRESS: Berlin Md.

25a. REC'D BY REGISTRAR DATE: APR 22 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20M 1/65

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1SME (5)
5M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06180

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06176

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Wicomico River

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury 22-1
d. STREET ADDRESS: 162 Sheldon Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First WILLIAM (BILLY) Middle CORBETT Last TOWNSEND

4. DATE OF DEATH: Month APRIL Day 30 Year 1966

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec. 1/1959

9. AGE (In years last birthday): 6 yrs. IF UNDER 1 YEAR: Months 04 Days 29 IF UNOER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): School boy

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Salisbury, Maryland

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Donald Corbett Townsend

14. MOTHER'S MAIDEN NAME: Ruth D. Long

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mr. Donald C. Townsend (Father) Address: Same as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Drowning — INTERVAL BETWEEN ONSET AND DEATH: Sudden
9298
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): Wading in river and stepped in over head.

20c. TIME OF INJURY Month, Day, Year: Hour 5:30 a.m. ☒ p.m. ☐ 4/30 1966

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): River

20f. (City or town) Salisbury (County) Wicomico (State) Maryland

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Dr. Earl L. Royer M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county): 409 Camden Ave. Salisbury, Md

22. DATE SIGNED: May 3 /1966

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: May 5/1966
23c. NAME OF CEMETERY OR CREMATORY: Siloam Church Cemetery
23d. LOCATION (City, town or county) (State): Siloam, Maryland

24. FUNERAL DIRECTOR: HOLLOWAY & COMPANY ADDRESS: SALISBURY, MARYLAND

25a. REC'D BY REGISTRAR DATE: MAY 5 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06181 (M) 06177

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: WICOMICO
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b: 5 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): PENINSULA GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 1104 Camden Ave.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First DeWitt; Middle Ross; Last TULL
4. DATE OF DEATH: Month APRIL; Day 6; Year 1966
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1-2-1895
9. AGE (In years last birthday): 71 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Salesman
10b. KIND OF BUSINESS OR INDUSTRY: Wholesale Groc.
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry Clay Tull
14. MOTHER'S MAIDEN NAME: Margaret Elizabeth Ross

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes
(If yes give war or dates of service): W.W.I
16. SOCIAL SECURITY NO.: 214-10-8268
17. INFORMANT: Mrs. Helen S. Tull, Same — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive heart failure
4200
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic heart disease
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: 1 MON. / YEARS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): NO.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year; Hour a.m. p.m.; 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from 11-15, 1963, to 4-6, 1966 that (I) (~~we~~) last saw the deceased alive on 4-6 1966, and that death occurred at 4 P M, from the causes and on the date stated above.

22a. SIGNATURE: Hubert R. White, Jr. M.D. ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 4-6-66
22c. PHYSICIAN'S NAME (Type): Dr. Hubert R. White, Jr.
22d. ADDRESS: Fruitland, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 4-8-1965
23c. NAME OF CEMETERY OR CREMATORY: Wicomico Memorial Park
23d. LOCATION (City, town or county) (State): Salisbury, Maryland

24. FUNERAL DIRECTOR: Hill Funeral Home
ADDRESS: Salisbury, Maryland
25a. REC'D BY REGISTRAR DATE: APR 11 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06182 — 06178

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 67 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Deer's Head State Hospital, Salisbury, Md.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Quantico, RFD #1
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
	Clifford	Irvin	Twilley		April	16	1966

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White	☒ MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED	March 14/1896	70 yrs.	1	2		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Employee-Pump Co.(Retired)
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Rural Quantico, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Irvin Twilley
14. MOTHER'S MAIDEN NAME: Lillie E. Hearn

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 215-14-3837
17. INFORMANT: Mrs. Lida B. Twilley (Wife) R.D.#1 Quantico, Maryland — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Coronary Thrombosis	15 mins
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. DUE TO (b)	Arteriosclerotic CVD	?
DUE TO (c)		

4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Infections Polyneuritis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from February 9, 1966 to April 16, 1966, that (I) (we) last saw the deceased alive on April 16, 1966, and that death occurred at 1:45 M, from the causes and on the date stated above.

22a. SIGNATURE: Robert J. Gore M.D.
M.O. ATTENDING PHYS. ☐ MED. DIRECTOR ☑ STAFF PHYS. ☐
22b. DATE SIGNED: 4/16/66
22c. PHYSICIAN'S NAME (Type): Robert J. Gore
22d. ADDRESS: Deer's Head State Hospital, Salisbury, Md

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
Burial	Apr. 20/1966	Parsons Cemetery	Salisbury, Maryland

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
HOLLOWAY & COMPANY	SALISBURY, MARYLAND	APR 20 1966	J. Charles Judge

VR A15 (4)
20M 1/65

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06183 #06179~~0617~~9

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Willards (Rural)
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): R.D.# 1

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Willards (Rural)
d. STREET ADDRESS: R.D.# 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First VIRGIL — Middle IEVIN — Last TYNDALL
4. DATE OF DEATH: Month APRIL — Day 14 — Year 1966
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 28/1912
9. AGE (In years last birthday): 53 yrs. — IF UNDER 1 YEAR: Months 10 Days 16 — IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Nursery
11. BIRTHPLACE (County & State, or foreign country): Wicomico Co., Maryland
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: Elmer Lee TYndall
14. MOTHER'S MAIDEN NAME: Mamie Addie Bratten
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
16. SOCIAL SECURITY NO.: 212-18-6214
17. INFORMANT: Mrs. Clara E. Hudson (Sister) — Address: R.D. #1 Parsonsburg, Maryland (301-749-6830)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] #21801
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 1-2 years
4222
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
DUE TO (b) Bronchial asthma
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Obesity
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): N/A
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1964 Apr., 19__, to 4-14, 1966, that (I) (we) last saw the deceased alive on 4-13 1966, and that death occurred at 5a M, from the causes and on the date stated above.

22a. SIGNATURE: Frank Lewis — M.O. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Apr. 16 /1966
22c. PHYSICIAN'S NAME (Type): Dr. Frank R. Lewis
22d. ADDRESS: Willards, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Apr. 16/1966
23c. NAME OF CEMETERY OR CREMATORY: Line Church Cemetery
23d. LOCATION (City, town or county) (State): Near Wicomico Co., Md.

24. FUNERAL DIRECTOR — ADDRESS: HOLLOWAY & COMPANY SALISBURY, MARYLAND
25a. REC'D BY REGISTRAR DATE: APR 20 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06184 — Item 3 Film 6575 4/20/66 ma — 06180

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Wicomico
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
   c. LENGTH OF STAY IN 1b
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Delaware
   b. COUNTY
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Delmar 46-3
   d. STREET ADDRESS: 908 E. State Street
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Adolph Middle Hector Last Valliere
4. DATE OF DEATH: Month April Day 6 Year 1966
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6-1-1888
9. AGE (In years last birthday): 77 yrs. IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CUSTODIAN
10b. KIND OF BUSINESS OR INDUSTRY: CHURCH
11. BIRTHPLACE (County & State, or foreign country): CANADA
12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: HENRY VALLIERE
14. MOTHER'S MAIDEN NAME: FANNY LEPITE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO (If yes give war or dates of service): —
16. SOCIAL SECURITY NO.: 127-01-3544
17. INFORMANT: ALICE VALLIERE — Address: DELMAR - MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: Unknown
   DUE TO (b): Nephrosclerosis, advanced
   DUE TO (c):
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
   446X
   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e): Gastrointestinal Hemorrhage
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

2Da. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4/5, 1966 to 4/6, 1966, that (I) (we) last saw the deceased alive on 4/6 1966, and that death occurred at 11:12 AM, from the causes and on the date stated above.

22a. SIGNATURE: David J. Gilmore — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 4-11-66
23c. NAME OF CEMETERY OR CREMATORY: ST. STEPHENS PARK
23d. LOCATION (City, town or county) (State): DELMAR - DEL

24. FUNERAL DIRECTOR: Charles W. Harmel — ADDRESS: Delmar, DEL
25a. REC'D BY REGISTRAR — DATE: APR 11 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06185 06181

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: WICOMICO
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): PENINSULA GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WORCESTER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OCEAN CITY
d. STREET ADDRESS: 109 TALBOT
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HERBERT Middle RECORD Last WHITE JR.

4. DATE OF DEATH: Month APRIL Day 20, Year 1966

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: SEPT 6 1903

9. AGE (In years last birthday): 62 yrs.
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED ARMY

10b. KIND OF BUSINESS OR INDUSTRY: RESERVE

11. BIRTHPLACE (County & State, or foreign country): FORESTVILLE N.Y.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: HERBERT R. WHITE

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): YES
(If yes give war or dates of service): WORLD WAR

16. SOCIAL SECURITY NO.: 055-14-3426

17. INFORMANT: MR. ROBERT WHITE Address: BERLIN MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): A Coronary Occlusion Heart Disease
4200
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: Few Hours

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

2Da. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

2Dc. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

2Dd. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

2Df. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4-20, 1966 to 4-20, 1966 that (I) (we) last saw the deceased alive on 4-20 1966 and that death occurred at 3:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE: [signature]
M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4-22-66

22c. PHYSICIAN'S NAME (Type):

22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 4/23/66

23c. NAME OF CEMETERY OR ~~CREMATORY~~: RIVERSIDE

23d. LOCATION (City, town or county) (State): BERLIN MD

24. FUNERAL DIRECTOR: Anna A. Burbage ADDRESS: Berlin Md

25a. REC'D BY REGISTRAR DATE: APR 26 1966

25b. REGISTRAR'S SIGNATURE: [signature]

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06186 (1) (M) 06182

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: WORCESTER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BERLIN
d. STREET ADDRESS: BAY ST
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ARMON — Middle H. — Last WILLIAMS
4. DATE OF DEATH: Month April — Day 24 — Year 1966

5. SEX: Male
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: MAY 1, 1889
9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED
10b. KIND OF BUSINESS OR INDUSTRY: FARMER
11. BIRTHPLACE (County & State, or foreign country): BERLIN MD
12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: SAMPSON WILLIAMS
14. MOTHER'S MAIDEN NAME: LEAH BETHARDS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 217-28-3368
17. INFORMANT: MRS. A.H. WILLIAMS — Address: BERLIN MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH
332X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic cerebral vasc. disease
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Generalized arteriosclerosis & diabetes
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from Apr 20, 1966, to April 24, 1966, that (I) (we) last saw the deceased alive on 24 April 1965, and that death occurred at 1:35 A M, from the causes and on the date stated above.

22a. SIGNATURE: Joseph C. Fitzgerald — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 24 April
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS: Medical Center Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 4/27/66
23c. NAME OF CEMETERY ~~OR CREMATORY~~: EVERGREEN
23d. LOCATION (City, town or county) (State): BERLIN MD.

24. FUNERAL DIRECTOR — ADDRESS: Anna A. Burbage Berlin Md.
25a. REC'D BY REGISTRAR — DATE: APR 28 1966
25b. REGISTRAR'S SIGNATURE: J Charles Judge

Eastern Std time.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

M 06187 — 0618.3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pocomoke — 23-2
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Warner — Middle: — Last: Wilson

4. DATE OF DEATH: Month: April — Day: 19 — Year: 1966

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct. 28, 1887

9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: Noah Wilson

14. MOTHER'S MAIDEN NAME: Sarah Jester

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 217-28-7638

17. INFORMANT: Address: Cynthia Wilson - Pocomoke, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage. — INTERVAL BETWEEN ONSET AND DEATH: 8 hrs.
443X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Hypertensive A.S.C.V. Disease. — 4 years.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4/18, 19 66, to 4/19, 19 66, that (I) (we) last saw the deceased alive on 4/18, 19 66, and that death occurred at 2:59 P.M., from the causes and on the date stated above.

22a. SIGNATURE: [signature]
M.D. ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED:

22c. PHYSICIAN'S NAME (Type):

22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4-23-66

23c. NAME OF CEMETERY OR CREMATORY: Georgetown

23d. LOCATION (City, town or county) (State): Pocomoke md

24. FUNERAL DIRECTOR: Samuel Lamb — ADDRESS: New Church, Va.

25a. REC'D BY REGISTRAR DATE: APR 25 1966

25b. REGISTRAR'S SIGNATURE: J Charles Judge

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06188

CERTIFICATE OF DEATH

06184

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in all events, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 5Yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Sp. Hill Pr. Sani.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wiomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ADDIE — Middle BELLE — Last WOOLF

4. DATE OF DEATH: Month 4 — Day 24 — Year 19 66

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Aug. 25, 1893

9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles E. Williams

14. MOTHER'S MAIDEN NAME: Adaline Waller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give wor or dotes of service): —

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Mr. John Woolf, Chatham, N.Y.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH
332X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Cerebral Arteriosclerosis
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) ~~(this hospital)~~ attended the deceased from August 18, 1961, to Apr. 1/24 19 66 that (I) ~~(we)~~ last saw the deceased alive on April 13 1966, and that death occurred at 6:35 p.M, from causes and on the date stated above.

22a. SIGNATURE: Thomas C. Hill Jr., M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: April 25, 1966

22c. PHYSICIAN'S NAME (Type): THOMAS C. HILL, JR. MD

22d. ADDRESS: Pine Bluff Rd., Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4-27-1966

23c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery

23d. LOCATION (City or Town) (County) (State): Salisbury, Maryland

24. FUNERAL DIRECTOR — ADDRESS: Hill Funeral Home — Salisbury, Maryland

25a. REC'D BY REGISTRAR DATE: APR 26 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

Norman T. Baker

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06189 06185

1. PLACE OF DEATH
a. COUNTY: Wicomico MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 981 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Deer's Head State Hospital, Salisbury, Md.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Berlin
d. STREET ADDRESS: Rt. #3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Harry Middle Last Yarborough
4. DATE OF DEATH: Month April Day 14 Year 1966
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 7/3/1883
9. AGE (In years last birthday): 82 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Worked on Fish Boat
10b. KIND OF BUSINESS OR INDUSTRY: Fishing
11. BIRTHPLACE (County & State, or foreign country): Richmond, Va.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: James P. Yarborough
14. MOTHER'S MAIDEN NAME: Katherine Bowie
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): UNK. (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 261-24-0925
17. INFORMANT Address: Deer's Head Hospital, Salisbury, Md. (Record)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Uremia due to renal insufficiency — INTERVAL BETWEEN ONSET AND DEATH: Days
603 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Status post fracture of left hip
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8/7, 1963 to 4/14, 1966, that (I) (we) last saw the deceased alive on 4/14 1966, and that death occurred at 2:50 P.M., from the causes and on the date stated above.

22a. SIGNATURE: C. F. Gutierrez-Garrido M.D. — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 4/15/66
22c. PHYSICIAN'S NAME (Type): C. F. Gutierrez-Garrido, M.D.
22d. ADDRESS: Deer's Head State Hospital, Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE THEREOF: 4-20-66
23c. NAME OF CEMETERY OR CREMATORY: Cemetery Rd
23d. LOCATION (City, town or county) (State): Balto Md

24. FUNERAL DIRECTOR: Barker M West — ADDRESS
25a. REC'D BY REGISTRAR DATE APR 21 1966
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65